☐PREADMISSION COMPLETE
☐ALERT PRESENT

VICTORIAN GUT CENTRE

Iron Infusion Admission Form

Please complete and return this form at least one week before your procedure.

Address: 119 Plenty Rd, Bundoora, VIC 3083
Ph: (03) 9466 8466 Fax: (03) 9466 8455
Email: reception@vicgut.com.au

Date of admission: dd/mm/yyyy

GENERAL INFORMATION

How did you hear about us? ☐GP ☐Specialist/Surgeon ☐Internet ☐Friend/Relative ☐Previous Patient

Have you had a consult with a gastroenterologist or surgeon in the last 30 days? ☐Yes ☐No

LAST NAME:	**TITLE**	**GIVEN NAME/S:**	**PREFERRED NAME:**

Home address:	**Suburb:**	**Postcode:**

Date of birth: dd/mm/yyyy	**Email:**	**Height**
Age:	**Mobile:**	**Weight**
Country of birth:	**Home Ph:**	**BMI**

Pronouns	☐She/her	☐He/him	☐They/them	☐Different term, specify:	☐By name
Gender	☐Female	☐Male	☐Non-binary	☐Different term, specify:	☐Prefer not to say
Sex at birth	☐Female	☐Male	☐Another term, specify		

Are you of Aboriginal or Torres Strait Islander Origin?

☐No ☐Yes, Aboriginal ☐Yes, Torres Strait Islander ☐Yes, Both Aboriginal and Torres Strait Islander ☐Decline to Answer

Do you have any religious/cultural needs? ☐Yes ☐No If yes, specify

Do you need an interpreter? ☐Yes ☐No If yes, ☐family to interpret ☐professional interpreter

Preferred language: (*Costs apply if no Medicare*)

Referring doctor's name:	Address:	Phone:

MEDICARE, HEALTH FUND AND OTHERS

Medicare Number:	**No. In Front of Name:**	**Expiry:** ☐ Do not have Medicare
Individual Health Identifier for My Health Record (MHR):		☐ Do not upload to MHR
Private Health Insurance: Yes / No	Fund Name:	Membership no:
Are you currently an in-patient in any hospital? Yes / No	Any excess paid in the last 12 months? Yes / No	Excess Or Co-Payment: $
Department Of Veterans Affair (DVA) Yes / No	DVA Card Number:	Card Colour: ☐ Gold ☐ White
Is this a Workcover or TAC:	Yes / No	Workcover or TAC approval number:

PLANNING FOR YOUR CARE

CERTIFICATE/S	☐Medical certificate ☐Carer certificate ☐Not applicable		
NEXT OF KIN OR EMERGENCY CONTACT	Name:	Relationship:	Contact number:

VICTORIAN GUT CENTRE

URN
Name
DOB
[place bradma label here]

HEALTH QUESTIONNAIRE DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS? IF YES, PLEASE PROVIDE FURTHER INFORMATION		
1. Blood pressure ☐ High ☐ Low	☐ Yes ☐ No	Is it controlled with medication?
2. Heart attack, arrhythmia or irregular heartbeat, angina or chest pain	☐ Yes ☐ No	When?
3. ☐Heart surgery ☐Pacemaker ☐Defibrillator ☐Stents ☐Other heart problems	☐ Yes ☐ No	Last date of check up with cardiologist?
4. ☐Asthma ☐Other lung issues ☐Shortness of breath	☐ Yes ☐ No	Is it controlled with medication? When was the last asthma attack? **PLEASE BRING YOUR PUFFER**
5. Diabetes ☐Type 1 ☐Type 2	☐ Yes ☐ No	☐Diet controlled ☐Tablets ☐Insulin
6. ☐ Kidney disease ☐Bladder problems	☐ Yes ☐ No	☐Dialysis ☐Renal Impairment ☐Other, specify ☐Incontinence ☐Urinary Retention ☐Stoma
7. Blood clots in the ☐legs or ☐lungs ☐Stroke	☐ Yes ☐ No	When? Resolved?
8. Blood disorders	☐ Yes ☐ No	☐Anaemia ☐Low Iron ☐Bruising or bleeding tendency
9. ☐Epilepsy ☐Seizures (Fits)	☐ Yes ☐ No	When?
10. ☐Blackouts ☐Dizziness ☐Balance problems	☐ Yes ☐ No	Frequency of attacks ☐Daily ☐Weekly ☐Monthly ☐Yearly When was the last attack?
11. ☐Short term memory loss ☐Dementia	☐ Yes ☐ No	Specify
12. Have you had an iron infusion in the past?	☐ Yes ☐ No	If yes, did you have a reaction?
13. ☐ Visual condition ☐ Hearing condition ☐ Dental condition	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	☐Glasses ☐Contact Lenses ☐Other, specify ☐Hearing Aids ☐Other, specify ☐Dentures ☐Caps ☐Crowns ☐Implants ☐Recent dental treatment ☐Loose/chipped tooth
14. Lymphoedema (swelling in arms or legs)	☐ Yes ☐ No	Location:
15. Other medical conditions or disabilities not already mentioned	☐ Yes ☐ No	Specify:
16. Do you suffer from ☐anxiety, ☐depression, ☐other mental conditions?	☐ Yes ☐ No	Specify:
17. Have you had an episode of delirium or aggression while in hospital?	☐ Yes ☐ No	Specify:
18. Do you use recreational drugs?	☐ Yes ☐ No	What do you take and how often? **PLEASE DO NOT TAKE 2 DAYS BEFORE YOUR PROCEDURE**
19. Could you be pregnant?	☐ Yes ☐ No	
20. Do you have an advanced care directive or treatment limiting order?	☐ Yes ☐ No	***This is a document that lists your preferences for future medical treatment i.e. consenting to or refusing specific types of treatment, should you lose decision-making capacity. If yes, please attach a copy to this form.***
21. **Infection:** Do you have any multi-resistant infections?	☐ Yes ☐ No	☐MRSA ☐VRE ☐CRE ☐C. Difficile ☐Other, specify: Active or inactive?
22. Do you have/have you had COVID-19?	☐ Yes ☐ No	When? Fully recovered?
23. Have you been unwell in the past 2 weeks?	☐ Yes ☐ No	Details:
24. Have ☐you or a ☐family member been recently exposed to a communicable disease?	☐ Yes ☐ No	☐ Shingles ☐ Chickenpox ☐ Measles ☐ Whooping cough ☐ Other, specify

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[place bradma label here]

25. Have you returned from an overseas trip in the past 30 days?	☐ Yes ☐ No	Details Have you been unwell since return?
26. Have you been hospitalised overseas or in another facility in the past 12 months?	☐ Yes ☐ No	Hospital: Date: Reason:
27. **Skin integrity:** Do you have wounds or breaks in your skin?	☐ Yes ☐ No	Details: **Please cover with dressing, if possible.**
28. **Falls history:** Have you had a fall in the last 12 months?	☐ Yes ☐ No	☐Slipped ☐Tripped ☐Lost balance - when? Did you sustain an injury?
29. Limb paralysis or weakness - ☐right ☐left	☐ Yes ☐ No	Any limitations in movement?
30. Do you use a walking aid?	☐ Yes ☐ No	☐ Stick ☐ Frame ☐ Other, specify **MUST BRING ON ADMISSION DAY**
31. Do you need help with ☐moving ☐dressing or ☐undressing?	☐ Yes ☐ No	Details:
32. Do you have anaphylaxis?	☐ Yes ☐ No	Details: **PLEASE BRING YOUR ADRENALINE AUTOINJECTOR, IF ANY**
33. Do you have any known allergies or adverse reactions?	☐ Yes ☐ No	Details: Reactions:
34. Do you have a dietary restriction or food intolerance?	☐ Yes ☐ No	Details: Reactions:

CURRENT MEDICATIONS

Please list all medications below. Include: blood thinners, steroids, diabetic medications, over the counter medications, inhalers, topical, eye drops, pain relievers, herbal medication. **Please attach a separate sheet if required**

Medication	Dose	Medication	Dose

PATIENT'S DECLARATION

I hereby declare that the above information is true and correct to the best of my knowledge.

Name Signature Date: DD / MM / YYYY

PRE-ADMISSION NURSE TO COMPLETE THIS SECTION (Tick all that applies)

ALERT form ☐Completed ☐Not applicable ☐Patient is currently well (no cough, cold or other illness) ☐Suitable for admission ☐Not suitable for admission	☐Current medications list attached and patient has not started taking new medication ☐Not applicable

Pre-admission notes:

Pre-admission completed by (initials): Date DD/MM/YYYY Time: hrs

OFFICE USE ONLY

☐Patient ID and procedure confirmed	Admin initials:	Time: