

UR No: \_\_\_\_\_  
 Surname: \_\_\_\_\_  
 Given Names: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Doctor: \_\_\_\_\_

AFFIX PATIENT LABEL

# Patient Admission Form

Please PRINT clearly. Your responses are very important in planning your admission and caring for you during your stay.

Please complete and return your completed Patient Admission Form, Financial & Privacy Consent Form and Health Questionnaire to the Northern Endoscopy Centre at least **FIVE (5) days prior** to your admission. You can do this by delivering the forms in person to our reception staff, via post or by emailing [bookings@northernendoscopy.com.au](mailto:bookings@northernendoscopy.com.au)

## PERSONAL DETAILS

Title	Surname	
Previous surname (if applicable)		
Given names		Preferred name
Date of Birth	/ /	Age Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Street Address		
Suburb	State	Post Code
Postal Address (if different to above)		
Suburb	State	Post Code
Phone Home ( )	Work ( )	Mobile
Email		
Country of Birth	Are you a Permanent Resident of Australia?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Main language spoken at home?	Do you require an interpreter?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Occupation	Religion	
Marital status	<input type="checkbox"/> Single <input type="checkbox"/> Married or Defacto <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	
Race	<input type="checkbox"/> Caucasian <input type="checkbox"/> Asian <input type="checkbox"/> Aboriginal <input type="checkbox"/> TSI <input type="checkbox"/> Other (specify) <input type="checkbox"/> Decline to Answer	

## PERSON TO CONTACT (NEXT OF KIN)

Title	Surname	Given name
Relationship to patient		
Address		
Suburb	State	Post Code
Phone Home ( )	Work ( )	Mobile
<b>Alternative contact person</b>	Phone	Relationship

## WHO IS YOUR GP/LOCAL DOCTOR

Full name of Doctor		
Address		
Suburb	State	Post Code
Phone ( )	Fax ( )	Email

## HOSPITAL PRE ADMISSION PLANNING

Have you been a patient at any other hospital within the past (7) days?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If <b>YES</b> , which hospital:	Dates of hospitalisation / / to / /
During this hospitalisation, were you admitted as a	<input type="checkbox"/> Private patient, or <input type="checkbox"/> Public patient
Do you have any of the following directives relating to the management your care and health? (tick)	<input type="checkbox"/> None
<input type="checkbox"/> Enduring Power of Attorney (Financial Decisions)	<input type="checkbox"/> Advance Care Directive / Advance Care Plan (Medical)

**IF YES TO ANY OF THESE, PLEASE PROVIDE A COPY OF THE DOCUMENTATION / DIRECTIVES TO THE HOSPITAL**

# Patient Admission Form

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## ENTITLEMENTS

Medicare No.		No. Prefixing name (IRN)	[ ]	Valid to	/
Department of Veterans' Affairs file No.				Expiry date	/
Department of Veterans' Affairs health card classification: <input type="checkbox"/> Gold <input type="checkbox"/> White <input type="checkbox"/> Other					
If <b>DVA</b> , do you require transport to be booked and organised for you? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Pensioner Concession Card (CRN) No.				Expiry date	/

## PERSON RESPONSIBLE FOR THE FINANCIAL ACCOUNT

Is the patient responsible for this account?     **Yes** (go to next section)     **No** (complete this section)

Title	Surname	Given name
Relationship to patient		
Address		
Suburb	State	Post Code
Phone Home (    )	Work (    )	Mobile

## HEALTH INSURANCE DETAILS

**INSURED PATIENTS:** it is recommended that you contact your health fund prior to completing this section to check your level of cover, particularly if you have been a member for less than 12 months or have changed your cover in the same period. Please be aware of the **PRE-EXISTING CONDITION RULE**. It is important that you are aware of all financial costs relating to your stay in hospital. Doctors and Anaesthetists are covered under the no gap scheme. **Accepted methods of payment on admission are: Cash, EFTPOS, or Credit Card (VISA or MasterCard).**

Health fund name:	Membership number:
Have you had private health insurance with the same provider for over 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have an <b>excess</b> or <b>co-payment</b> to pay? <input type="checkbox"/> Yes <input type="checkbox"/> No    If <b>YES</b> , how much? \$	

**ANY HOSPITAL EXCESS OR CO-PAYMENT MUST BE PAID PRIOR TO YOUR ADMISSION**

## OUT OF POCKET EXPENSES FOR PATIENTS

Have the hospital staff and or treating physician explained to you the financial account details in relation to your admission and treatment?     Yes     No

**IF YOU ANSWERED NO, IT IS RECOMMENDED YOU TALK TO THE HOSPITAL STAFF WELL PRIOR TO YOUR PLANNED ADMISSION TO OBTAIN DETAILED INFORMATION ABOUT ANY OUT OF POCKET EXPENSES THAT MAY APPLY**

## SELF FUNDED (UNINSURED) PATIENTS

Please obtain information regarding your planned procedure from your referring doctor or doctor's rooms, and then contact the hospital for an estimate of costs.

**ALL COSTS FOR UNINSURED PATIENTS ARE PAYABLE PRIOR TO ADMISSION AND ARE NOT COVERED BY MEDICARE**

## COMPENSABLE ADMISSIONS (IF APPLICABLE)

If your planned procedure is as a result of a Return to Work SA (Workcover) or third party insurance claim, then please contact the hospital to discuss your circumstances in conjunction with the required booking process.

Name of insurance company	
Insurance claim or reference number:	Date of accident    /    /
Claim contact person	Phone (    )    Fax (    )
Claim email	

**WRITTEN APPROVAL FOR THIS ADMISSION (FROM YOUR INSURANCE COMPANY) MUST ACCOMPANY THIS FORM**

# Patient Financial and Privacy Consent Form

UR No: \_\_\_\_\_

Surname: \_\_\_\_\_

Given Names: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Doctor: \_\_\_\_\_

AFFIX PATIENT LABEL

The Federal Privacy Act 1988 (Privacy Act) with amendments, states that your consent needs to be obtained prior to our collecting personal and health information about you. Please read carefully the Privacy Policy Information, which provides details related to the management of your Personal Health Information, prior to signing this consent form.

I, \_\_\_\_\_ (being the Authorised Person)  
(print full name)

being the  patient, or  parent, or  guardian of

\_\_\_\_\_ (print full name of patient if the Authorised Person is the patient's parent or guardian)

acknowledge and consent to the following:

## FINANCIAL CONSENT

- I agree to take full responsibility for any financial accounts rendered by the Northern Endoscopy Centre, including any shortfall in reimbursement by my health fund or any insurance company gap following settlement by the health fund and/or insurance company.
- I have had the financial costs of my hospitalisation and procedure clearly explained to me and understand that:
  - total costs cannot be quoted, but only estimated in advance of my procedure;
  - my obligation to pay for my hospitalisation is independent of any benefits I may be able to claim for my private health insurance and that I will be liable for any debt collection and or legal fees incurred in the collection of these accounts.
- I acknowledge that if I have been a member of a private health fund for less than 12 months or have changed cover in the same period, that I am fully aware of the PRE-EXISTING CONDITION RULE regarding eligible benefits payable by my health fund.
- I understand that any excess payable under my private health insurance fund will be paid on or prior to admission.
- I understand that I may be required to pay for some prosthetics or speciality items deployed in theatre that may not be covered by my health fund.

## PRIVACY AND PERSONAL INFORMATION CONSENT

- I have read the hospital information booklet provided to me and are aware of the Northern Endoscopy Centre policy for the management of personal health information.
- I understand I am not obliged to provide any information requested of me, but that my failure to do so may compromise the quality of the healthcare and treatment given to me.
- I am aware of my right to access the information collected about me, except in some circumstances where access may be legitimately withheld. I understand I will be given an explanation in these circumstances.
- I understand that if my personal and health information is to be used for any other purpose than set out in the information provided, my further consent will be obtained.
- I understand that I may notify the hospital of specific limitations on access or disclosure which will be documented in my health record.
- I consent to the handling of my personal health information by the Northern Endoscopy Centre for the purposes set out in the information provided, subject to any limitations on access or disclosure that I notify the hospital of.

**SIGNATURE OF PERSON RESPONSIBLE \***  
**(FINANCIAL AND PRIVACY CONSENT)**



DATE / /

\* A "person responsible" means a person defined as a "person responsible" under the Federal Privacy Act 1988 (Privacy Act) with amendments including the patient's partner, family member, carer, guardian, close friend and a person exercising power under an enduring power of attorney.

**Should you require any assistance or clarification regarding any aspects of your financial requirements or personal information usage within the hospital, please do not hesitate to contact our staff.**

UR No: \_\_\_\_\_  
 Surname: \_\_\_\_\_  
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 Date of Birth: \_\_\_\_\_ Doctor: \_\_\_\_\_

# Health Questionnaire

Please PRINT clearly. Your responses are crucial to ensure we care for you during your stay.

**IMPORTANT:** We depend on you to provide accurate health screening information. To help us streamline your hospital admission and discharge and allow nursing care to be planned to meet your individual needs, you are required to complete and return this Questionnaire along with your other preoperative admission forms at least **(5) days prior** to your procedure. Please complete **ALL** pages. If you have any questions, please contact the hospital for assistance.

<b>PATIENT NAME:</b>			
Date of Birth	/	/	Contact telephone
Sex	<input type="checkbox"/> Male	<input type="checkbox"/> Female	

## MEDICAL HISTORY

Have you ever had a <b>reaction</b> to:	If <b>Yes</b> , please specify details of any allergies or sensitivities	STAFF USE
<b>DRUGS</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>FOOD</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>LATEX</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>OTHER</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
What is your weight? kilograms	What is your height? centimetres	<b>BMI:</b>
Have you had an <b>anaesthetic</b> before?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you, or any blood relatives, had <b>problems with anaesthetics</b> in the past?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you <b>smoke</b> or have you <b>smoked</b> in the past?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If <b>Yes</b> , specify daily quantity: date ceased: / /	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you <b>drink alcohol</b> ? If <b>Yes</b> , daily amount:	<input type="checkbox"/> Yes <input type="checkbox"/> No	

<b>CVS</b>	Have you ever had a <b>heart attack</b> ? If <b>Yes</b> , year:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Have you undergone <b>heart surgery</b> within the <b>past 6 months</b> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	●
	Have you <u>ever</u> undergone any <b>heart surgery</b> prior to 6 months? (e.g. bypass, stent) If <b>Yes</b> , year and specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Do you have a <b>pacemaker</b> or <b>implanted defibrillator</b> ? (circle)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Do you have <b>angina</b> ? If <b>Yes</b> , do you use <b>GTN patches / sublingual spray / tablets</b> ? (circle)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Do you have an <b>irregular heart rate</b> , <b>murmur</b> or <b>heart palpitations</b> ? (circle)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Have you ever had a <b>stroke / CVA</b> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Do you have a tendency to <b>bleed</b> , <b>clot</b> or <b>bruise</b> easily?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Have you ever had <b>high blood pressure</b> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Do you have any <b>other heart problems</b> ? If <b>Yes</b> , specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>RESP</b>	Do you have any <b>lung</b> or <b>chest</b> conditions? (e.g. asthma, bronchitis, emphysema) If <b>Yes</b> , specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Do you have <b>sleep apnoea</b> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Have you ever had <b>throat</b> , <b>nose</b> or <b>lung</b> surgery? If <b>Yes</b> , specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Do you use a <b>nebuliser</b> , <b>puffer</b> or <b>EPAP/CPAP</b> machine or use <b>home oxygen</b> ? If <b>Yes</b> , specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you had a <b>cold</b> , <b>flu</b> or unexplained temperature in the past 2 weeks?	<input type="checkbox"/> Yes <input type="checkbox"/> No	●	
<b>MET / RENAL</b>	Do you have <b>diabetes</b> ? <input type="checkbox"/> Insulin <input type="checkbox"/> Tablet <input type="checkbox"/> Diet Controlled <i>Please discuss with your doctor both prior to and after your procedure</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Do you have any <b>kidney</b> or <b>thyroid</b> problems? If <b>Yes</b> , specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Do you have any <b>bladder</b> problems? (e.g. incontinence, catheter, urgency) If <b>Yes</b> , specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	

# Health Questionnaire

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AFFIX PATIENT LABEL

		STAFF USE
<b>G</b>	Do you have <b>jaundice, hepatitis</b> (specify HEP type A, B, C) or <b>liver</b> disease? If <b>Yes</b> , specify: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have any <b>gastric</b> problems? (e.g. hiatus hernia, stomach ulcers, reflux) If <b>Yes</b> , specify: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have any <b>bowel</b> problems? (e.g. diarrhoea, constipation, incontinence, diverticulitis/stomas) If <b>Yes</b> , specify: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you had any recent <b>unintentional weight loss</b> ? If <b>Yes</b> , specify: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>FALLS RISK</b>	Do you have any <b>numbness</b> or <b>tingling</b> problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you experienced <b>fainting</b> or <b>dizziness</b> in the past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you had any <b>fits, convulsions</b> or <b>blackouts</b> ? (e.g. epilepsy) If <b>Yes</b> , specify: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you had any <b>falls</b> in the past 12 months? If <b>Yes</b> , specify: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have any <b>vision</b> problems? (e.g. limited vision, cataracts, glaucoma)	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have problems <b>weight bearing</b> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you wear <b>glasses / contact lenses</b> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>ASSISTANCE</b>	Do you have a <b>hearing aid</b> or other hearing appliance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have any <b>dentures / caps / crowns / loose teeth</b> ? (circle)	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have any <b>artificial joints</b> or limbs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever had <b>back / neck / jaw</b> surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have <b>mobility problems</b> ? (e.g. arthritis, back pain or leg weakness?)	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you use any <b>mobility aids</b> ? (e.g. frame, stick, crutches, wheelchair etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>CJD RISK</b>	Do you or any members of your family have a history of <b>Creutzfeldt Jakob Disease (CJD)</b> or other unspecified neurological disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you had a <b>dura mater graft</b> between 1972-1989?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you received <b>human pituitary hormones</b> (growth hormones, gonadotrophins) prior to 1985?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you been assessed for CJD or do you have a "medical in confidence letter" regarding your risk of CJD?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>OTHER</b>	Have you ever had a <b>multi-resistant organism infection</b> ? (MRSA, golden staph, VRE or CRE?) <i>If you are unsure, please contact the hospital immediately to discuss</i> If <b>Yes</b> , specify type and year (when): _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have or have you had any <b>other infections</b> or <b>infectious diseases</b> ? If <b>Yes</b> , specify type and year (when): _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you been in <b>contact with anyone</b> over the past 3 months who has had an infection or infectious disease? (e.g. Chicken Pox, Measles) If <b>Yes</b> , specify type: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have any <b>skin wounds, pressure sores</b> or <b>skin ulcers</b> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have an <b>intellectual disability</b> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have <b>Alzheimer's / dementia</b> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever experienced an episode of <b>delirium</b> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	[Female patients] : Are you or could you be <b>pregnant</b> ? If <b>Yes</b> , weeks: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any <b>other medical conditions</b> not specified above that we should be aware of? If <b>Yes</b> , specify: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	

# Health Questionnaire

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UR No: \_\_\_\_\_

Surname: \_\_\_\_\_

Given Names: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Doctor: \_\_\_\_\_

AFFIX PATIENT LABEL

## MEDICATIONS

Please remember to bring with you all your current medication (in original labelled containers) and any current or relevant medical reports to hospital. It is advisable that you **DO NOT** bring any valuable items into hospital, as the centre does not assume any responsibility for any valuables.

Do you take any <b>anti-coagulant</b> or <b>blood thinning medications</b> ? (e.g. Coumadin (warfarin), Xarelto (rivaroxaban), Eliquis (apixaban), Pradaxa (dabigatran), Iscover / Plavix (clopidogrel), Aspirin etc.) If <b>Yes</b> , name of medication:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you take any <b>steroids</b> , <b>anti-inflammatory</b> drugs or <b>cortisone</b> / <b>prednisolone</b> tablets / injections? If <b>Yes</b> , name of medication:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you use <b>recreational drugs</b> ? If <b>Yes</b> , what type and how much/frequency:	<input type="checkbox"/> Yes <input type="checkbox"/> No

### LIST OF CURRENT MEDICATIONS

Please list all medications you are currently taking  
 (prescription, non-prescription, including herbal – Krill / Fish Oil, Olive Leaf and vitamins)

MEDICATION	DOSE	DIRECTIONS	MEDICATION	DOSE	DIRECTIONS

## FAMILY MEDICAL HISTORY

YOUR FATHER	YOUR MOTHER
<input type="checkbox"/> <b>Alive</b> , current age: _____	<input type="checkbox"/> <b>Deceased</b> , at age: _____
<input type="checkbox"/> <b>Deceased</b> , at age: _____	<input type="checkbox"/> <b>Alive</b> , current age: _____
If <b>alive</b> , please specify any illnesses:	If <b>alive</b> , please specify any illnesses:
If <b>deceased</b> , please specify cause of death:	If <b>deceased</b> , please specify cause of death:
SIBLINGS (IF APPLICABLE)	YOUR CHILDREN (IF APPLICABLE)
<input type="checkbox"/> <b>Brothers</b> = _____	<input type="checkbox"/> <b>Sons</b> = _____
<input type="checkbox"/> <b>Sisters</b> = _____	<input type="checkbox"/> <b>Daughters</b> = _____
Please specify any illnesses (if applicable):	Please specify any illnesses (if applicable):
Please specify any cause of death (if applicable)	Please specify any cause of death (if applicable)

## PATIENT CONFIRMATION

I confirm my understanding and agree that:

- Following any procedure performed under IV sedation at this hospital, I will have a responsible adult drive me/accompany me home. I realise that mental impairment may persist for several hours following the administration of anaesthesia; and
- I have answered all the questions above to the best of my knowledge and have not purposely withheld any information that may compromise the quality of the healthcare and treatment given to me.

**SIGNATURE OF PATIENT**



DATE   /   /