GLEN IRIS PRIVATE

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Please complete this form and return to Glen Iris Private before your admission.

ADMISSION REGISTRATION

Please complete pages 1-3

SEPTEMBER 2016

DATE OF PROCEDURE: .....

SURNAME: ..... **Title:** ..... **Given Name:** .....

Preferred Name: .....

Please bring Medicare card (The last number is next to your given name)

MEDICARE CARD NO: (e.g.) | 3 | 5 | 5 | 5 | 4 | 6 | 5 | 2 | 1 | 5 | - | 3 |

MEDICARE CARD NO: | | | | | | | | | | | - | | (REF NO) **Valid to:** .....

ADDRESS: .....

Postcode: ..... **State:** ..... **SEX:** ◉ **M** ○ **F**

Home Phone: ..... **Work Phone:** ..... **Mobile:** .....

Date of Birth: ..... **Age:** ..... **Country of Birth:** ..... **Marital Status:** .....

Have you attended Glen Iris Private for a procedure before? ☑ **YES** ☐ **NO**

Have you been admitted to any other hospital within the past 7 days? ☑ **YES** ☐ **NO**

Aboriginal or TS Island descent: ☑ **YES** ☐ **NO**

Language spoken: ☐ ENGLISH ☐ OTHER .....

How will this admission be claimed?

☐ **Private Health Insurance:** Name of Fund ..... Membership number .....

☐ **Veterans Affairs:** File number .....

☐ **Workcover:** Name of Insurance company .....

☐ **Uninsured**

Do you have an Ambulance Victoria membership? ☑ **YES** ☐ **NO** .....

PATIENT COMPLIANCE STATEMENT:

Following the procedure, **I WILL** have a responsible adult drive me home, and have made arrangements for this to occur. I realise that impairment of full mental alertness may persist for several hours following the administration of anaesthesia and I will avoid making serious decisions or taking part in activities which depend on full concentration of judgement during this period. ***I WILL NOT DRIVE A CAR FOR THE REMAINDER OF TODAY.***

Where do you plan to go after discharge? ..... Who will take you there? .....

Are they waiting ☐ Or shall we call them ☐ What is their contact number.....

Who will care for you overnight after discharge:

Name: ..... Relationship: .....

Tel. No: .....

Patient Sign: ..... Witness: .....

Contact person in an emergency: Name: .....

Address: .....

Relationship: ..... Tel. No: .....

BINDING MARGIN - DO NOT WRITE

ADMISSION REGISTRATION

HEALTH INFORMATION

ID LABEL HERE

ALLERGIES: (Drugs, Dressings, Food or Latex)

.....

Do you have a Not For Resuscitation or Treatment Limiting form?

☑ **YES** ☐ **NO**

List your regular medications:

This must be completed even if the information is on your referral or you have already given it to the doctor. If you do not take any regular medications please say NIL below.

.....

.....

Have you had Cortisone or Steroids in the last 12 months? ☑ **YES** ☐ **NO**

Do you take any blood thinning agents e.g. Warfarin, Plavix, Iscover, Pradaxa etc? ☑ **YES** ☐ **NO**
(Please check with your GP or Cardiologist if you can stop this medication)

Have you or a relative had any complications due to a previous anaesthetic? ☑ **YES** ☐ **NO**

Do you smoke? ☑ **YES** ☐ **NO**

If yes, how many per day? .....

Have you ever had any serious illness, disease or previous operations? ☑ **YES** (Put details below) ☐ **NO**

.....

Have you had any recent minor illness or disease? ☑ **YES** (Put details below) ☐ **NO**

.....

PLEASE TICK ANY OF THE FOLLOWING WHICH YOU HAVE OR HAVE HAD: (put details below)

Heart trouble

☐ Chest pain/Angina ☐ Recent Cardiac Surgery ☐ Atrial Fibrillation

☐ Heart Attack ☐ Murmur ☐ Pacemaker / Internal Defibrillator

Diabetes (please bring your diabetic medication with you)

☐ Type 11 ☐ Type 1 ☐ Diet Controlled

Other existing conditions

☐ Blood clots Legs/Lungs ☐ High Blood pressure ☐ Stroke

☐ Epilepsy ☐ Psychiatric treatment ☐ Asthma

☐ Tuberculosis ☐ Persistent bleeding (Put details below)

Have you had a fall over the last 12 months? (Please put details below) ☑ **YES** ☐ **NO**

.....

.....

.....

DO YOU HAVE: Contact lenses ☐ Prosthesis ☐ Dental caps or crowns ☐ Dentures (false teeth) ☐

Have you had an infectious disease in the last 6 months e.g MRSA or VRE? ☑ **YES** ☐ **NO**

Have you had an overnight stay in an overseas hospital in the last 12 months? ☑ **YES** ☐ **NO**

Female patients are you or could you be pregnant ? ☑ **YES** ☐ **NO** Are you breast-feeding? ☑ **YES** ☐ **NO**

Referring doctor: Name ..... Phone.....

Address .....

Admin Staff to complete: Did you receive a Patient Information Brochure? ☑ **YES** ☐ **NO**

Do you have any questions? ☑ **YES** ☐ **NO** .....

Please put the date and time you last **ate** ..... **drank** .....

BINDING MARGIN - DO NOT WRITE

CONSENT:

I agree to follow the following instructions and understand that non-compliance with any of these could result in undesirable effects on other patients, members of the public, and myself:

☐ **I have received and understand the following information brochures and I have had the opportunity to ask questions prior to my procedure:**

- Colonoscopy and/or Gastroscopy information brochure.
- Patient Information brochure.
- Discharge Information brochure

☐ **I have had the following conditions of attending day surgery explained to me:**

- I will follow the specific Discharge instructions provided to me;
- **a responsible adult will be required to drive me home and stay with me overnight until the effects of the anaesthetic have worn off ;**
- I must not use public transport (buses or trains) to travel home post procedure;
- I should only use a taxi in the company of a second person;
- If I have not organised transport home with a responsible person, the procedure may be postponed.

☐ **During the first 12- 24 hours after my procedure, I must be supervised by a responsible adult. During that time, I should NOT:**

- drink alcohol, or take mind-altering substances;
- drive a car, bike or other vehicle;
- operate machinery including cooking implements;
- undertake heavy exercise;
- care for infants without responsible help;
- make important decisions or sign a legal document.

☐ **I consent to be contacted after leaving the hospital for a follow up phone call if required.**

☐ **I understand that in the event of an emergency if I cannot contact the hospital I should go to my local General Practitioner or to the nearest hospital emergency department.**

PATIENT/GUARDIAN NAME (PRINT): .....

PATIENT/GUARDIAN SIGNATURE: ..... DATE: .....

OVERNIGHT CARER NAME (PRINT): .....

OVERNIGHT CARER SIGNATURE: ..... DATE: .....

ACKNOWLEDGMENT:

To the best of my knowledge all the answers to all the questions are true and I have not withheld any information.

The nature of this procedure has been fully explained and I give permission for this to be carried out and the appropriate Local Anaesthetic and/or sedation and/or Anaesthetic to be administered.

Additional procedures or treatment may be needed if the doctor finds something unexpected and I agree to these additional procedures being carried out if required as long as they are related to the primary procedure.

I understand that should I require admission to hospital for further care I will be responsible for costs incurred.

I give my consent for the collection of sensitive information and I understand that Glen Iris Private will only collect health information that is necessary for its functions.

In the event of an unplanned complication during the procedure which requires a hospital transfer, I consent to Glen Iris Private arranging ambulance transportation. GIP recommends patients have ambulance cover prior as you will incur this cost.

I understand that I may withdraw my consent at any time prior to the procedure commencing.

DO NOT FILL OUT THIS PART OF THE CONSENT PRIOR TO YOUR ARRIVAL AT GIP

I hereby confirm that I have given consent to: (Name of doctor).....

To perform the procedure of:.....

PATIENT/GUARDIAN NAME (PRINT): .....

PATIENT/GUARDIAN SIGNATURE: ..... DATE: .....

SIGNATURE OF WITNESS: .....

SIGNATURE OF PROCEDURALIST: .....

BINDING MARGIN - DO NOT WRITE