GIH ACCESS ENDOSCOPY
DAY PROCEDURE CENTRE

PATIENT REGISTRATION FORM

Use BLOCK LETTERS or attach ID label

UR Number: .....

Surname: .....

First Name: .....

Other Names: .....

Address: .....

.....

DOB: ...../...../..... Doctor: .....

It is preferable that this form is received by this Day Procedure Centre within 7 days prior to admission.

Admission Date: Admitting Doctor:

Reason for Admission:

Have you been a patient of this Day Procedure Centre before? ☐ No ☐ Yes Date:

PATIENT DETAILS

Title: (please tick one) ☐ Master ☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Other:

The following names entered need to be formal, as per a birth certificate or passport. "Pet names" or abbreviated names are not to be used.

Surname: Former Surname (if applicable):

First Name: Middle Names:

Date of Birth: Gender: ☐ Female ☐ Male ☐ Other

Home Address:

No & Street Name:

Suburb: State/Territory: Post Code:

Country:

Postal Address: (write "as above" if the same as the Home Address)

Email Address:

Mobile Telephone No: **Home:** **Business:**

Marital Status: ☐ Single ☐ Married ☐ Defacto ☐ Separated ☐ Divorced ☐ Widowed

Country of Birth: If Australia, which State?

Are you an Australian Resident? ☐ Yes ☐ No If not what is your country of residence/citizenship?:

Do you require an interpreter? ☐ No ☐ Yes Language required?:

Indigenous Status: ☐ N/A ☐ Aboriginal ☐ Torres Straight Islander ☐ Both

Religion: Religious Dietary Requirements:

Do you have any specific beliefs or customs we need to consider when we are planning your care? ☐ No ☐ Yes What are they:

Financial Information

Medicare Card No: Medicare Card Reference No: Expiry Date:

Pension Card No: Expiry Date:

Health Care Card No: Expiry Date: Other:

DVA Card No: Card Colour: ☐ White ☐ Gold ☐ Other

Pharmaceutical Benefits Scheme (PBS) Safety Net Card No:

Ambulance Cover: ☐ No ☐ Yes Ambulance Membership No:

How Will This Admission Be Claimed? ☐ Self funded ☐ Private Health Insurance ☐ Veteran Affairs (DVA)

Private Health Insurance

Health Fund Name:

Membership No: Date Joined: Title/Level of Cover:

Has this level of cover changed in the last 12 months?: ☐ No ☐ Yes

Is there an excess? ☐ No ☐ Yes Amount $ Has an excess been paid this year? ☐ No ☐ Yes Amount $

Is the Patient a Minor (i.e Less than 18 years of age): ☐ No ☐ Yes

Information Relating to Minors

Name of Parent/Guardian/Legal Representative accompanying patient:

First Name: **Surname:**

Relationship to Patient:

Mobile Telephone: Home No: Business No:

Address:

Suburb: State/Territory: Post Code:

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UR Number: .....

Surname: .....

First Name: .....

Other Names: .....

Address: .....

.....

DOB: ...../...../..... Doctor: .....

All accounts relating to GIH Access Day Procedure Centre need to be settled prior to, or at the time of admission of the patient.

Name: Relationship To Patient:

Postal Address:

Telephone No: Email Address:

Documents, forms, correspondence will be sent via email unless otherwise stipulated. ☐ Email ☐ Postal ☐ Both

Previous Hospitalisation

Have you been admitted to a hospital or day procedure centre with 7 days prior 10 this admission? ☐ No ☐ Yes

Name of hospital /day procedure centre: Date:

General Practitioner Details

Name of G.P: Name of Practice:

Address of Practice:

Suburb: State/Territory: Post Code:

Email Address: Telephone No: Facsimile No:

Referring Doctor (if different than the G.P.)

Name of Referring Doctor: Name of Practice/Organisation:

Address:

Suburb State/Territory: Post Code:

Email Address: Telephone No: Facsimile No:

Next of Kin/Contact Details: *If the patient is a minor, a parent/ guardian/legal representative must complete below*

First Name: Surname:

Mobile Telephone No: Home No: Business No:

Address:

Suburb: State: Post Code: Country:

Relationship to Patient:

Do You Have an Enduring Power of Attorney? ☐ **No** ☐ **Yes** ☐ Medical ☐ Financial ☐ Guardian

Name: Contact Number:

Privacy Statement

I consent to GIH Access Endoscopy collecting, using and disclosing my personal information for my ongoing care ☐ No ☐ Yes

Declaration of Patient/Parent/Guardian/Legal Representative:

I agree that all information within this form is accurate and true, to the best of my knowledge

Full Name (Please print): Relationship to Patient:

Signature: Date:

GIH ACCESS ENDOSCOPY
DAY PROCEDURE CENTRE

MEDICAL & SURGICAL HISTORY

Use BLOCK LETTERS or attach ID label

UR Number: _____

Surname: _____

First Name: _____

Other Names: _____

Address: _____

_____

DOB: _____ / _____ /_____ Doctor: _____

Date form completed: _____ /_____ /_____

Completed by: ☐ Patient ☐ Parent/Guardian ☐ Next of Kin ☐ Carer ☐ Other _____

Do you have any specific beliefs or customs that we need to consider when we are planning your care? ☐ Y ☐ N
If yes, please give details.

Do you have any concerns, difficulties or pain that could affect the way we care for you during your stay? ☐ Y ☐ N
If yes, please give details.

Do you have a advanced care plan/directive? ☐ Y ☐ N
If yes, please attach a copy with paperwork

Is there anything else that is important to you today?

Height (cm) : **Weight (kg):** **BMI:**

If you do not know your accurate weight or height, please advise your doctor or reception.
For your safety, patients with a weight greater than 130kg or BMI greater than 40 will be referred to a tertiary hospital.

ALLERGIES / ADVERSE REACTIONS		DETAILS
Do you have any allergies / reactions	☐ Y ☐ N	
Do you have any allergies / reactions to food or other substances	☐ Y ☐ N	
Other	☐ Y ☐ N	

Do you take any MEDICATIONS? Yes, complete details below (please add list if insufficient space) No, go to next section

Include all prescribed and over the counter medications you currently take in any form (eg tablets, liquid, drops, ointment, puffers, patches, injections, herbal preparations etc)

Medication	Dose	Frequency	Comments

INFECTIONS AND INFECTION RISK: Please complete questions below. If yes please provide details and dates

Have you been overseas in the past 14 days? ☐ Y ☐ N

Have you been in close contact with someone with suspected or confirmed infectious diseases such as: Influenza, Chicken Pox, Measles, COVID-19 ☐ Y ☐ N

Have you been admitted overnight to any overseas health care facility in the past 12 months? ☐ Y ☐ N

Do you currently have a cough, symptoms of cold or flu or fever/high temperature? ☐ Y ☐ N

Do you currently have infective diarrhoea or vomiting? ☐ Y ☐ N

Do you have any other current infections or infection related issues? ☐ Y ☐ N

If you answered yes to any of the above please give details:

_____

_____

GIH ACCESS ENDOSCOPY
DAY PROCEDURE CENTRE

MEDICAL & SURGICAL HISTORY

Use BLOCK LETTERS or attach ID label

UR Number: _____

Surname: _____

First Name: _____

Other Names: _____

Address: _____

_____

DOB: _____ / _____ /_____ Doctor: _____

MEDICAL HISTORY Do any of the following apply to you? If yes, please provide details and dates

• Have you or a blood relative ever had an adverse reaction to an anaesthetic?	☐ Yes ☐ No	
• Heart condition	☐ Yes ☐ No	
• Blood pressure problems	☐ Yes ☐ No	
• Pacemaker or implanted defibrillator	☐ Yes ☐ No	Please bring identification details to hospital
• Blood clot in your lungs or legs	☐ Yes ☐ No	Year_____
• Sleep apnoea, disturbed sleep, snoring	☐ Yes ☐ No	
• Lung or breathing problems	☐ Yes ☐ No	
• Shortness of breath with normal daily activities	☐ Yes ☐ No	
• Liver disease or problems	☐ Yes ☐ No	
• Kidney disease or problems	☐ Yes ☐ No	
• Heartburn or reflux	☐ Yes ☐ No	
• Diabetes (please tick): ☐ Type 1 ☐ Type 2	☐ Yes ☐ No	☐ Insulin ☐ Diet ☐ Tablets
• Epilepsy, fits, blackouts, dizziness	☐ Yes ☐ No	
• Memory problems or dementia	☐ Yes ☐ No	
• Mental health problems or diagnosis	☐ Yes ☐ No	
• Physical disability	☐ Yes ☐ No	
• Fall in the last 3 months	☐ Yes ☐ No	
• Require mobility aids or unsteady on your feet	☐ Yes ☐ No	
• Live in assisted care or nursing home	☐ Yes ☐ No	
• Could you be pregnant	☐ Yes ☐ No	
• Any dental conditions	☐ Yes ☐ No	
• A diagnosis of cancer - if yes, see below	☐ Yes ☐ No	Are you undergoing cancer treatment currently?
Type:	☐ Yes ☐ No	Treatment type:
Site:	☐ Yes ☐ No	Date of last treatment:
• Require visual or hearing aids or prosthesis (if yes, tick)	☐ Yes ☐ No	☐ Glasses ☐ Contacts ☐ Hearing aids
• Current or past smoker	☐ Yes ☐ No	Number per day_____ Year quit_____
• Drink alcohol	☐ Yes ☐ No	Number of drinks per day / week _____
• Use recreational drugs	☐ Yes ☐ No	
• Any serious health problems not covered above	☐ Yes ☐ No	

PLANNING FOR YOUR DISCHARGE

Following your procedure, it is required that a responsible adult collect you from GIH Access Endoscopy and remain with you overnight

Name of person collecting you _____ Contact number _____

For 12 hours following your discharge you must not drive a car, operate heavy machinery, sign any legal documents or drink alcohol

HOSPITAL USE ONLY

☐ Gastroenterology consult ☐ Referred to Tertiary Facility ☐ Anaesthetic Review required

Nurse reviewing documentation: (Print name) _____ Sig: _____ Desig: _____ Date: ____ /____ /____

Nurse completing task: (Print name) _____ Sig: _____ Desig: _____ Date: ____ /____ /____

GIH ACCESS ENDOSCOPY
DAY PROCEDURE CENTRE
Level 1, 105/445 Princes Highway,
Officer 3809
Ph: 8614 5132 Fax: 8614 5133
Provider # 0037060T

INFORMED FINANCIAL CONSENT

Use BLOCK LETTERS or attach ID label

UR Number: .....
Surname: .....
First Name: .....
Other Names: .....
Address: .....
.....
DOB: ...../...../..... Doctor: .....

Admission Date:

PATIENT DETAILS

Title: (please circle one) Master Mr. Miss Mrs. Ms. Dr. Other:

Surname:

First Name: Middle Names:

Date of Birth: Gender: ☐ Female ☐ Male ☐ Other

Mobile Telephone No: **Home:** **Business:**

Address:

No & Street Name:

Suburb: State/Territory: Post Code:

Country:

Health Insurance

Health Fund Name: Excess: Verification Number:

Membership No: Date Joined: Title/Level of Cover:

You should check with your health insurance provider to confirm whether your level of insurance covers your required procedure(s).

☐ Colonoscopy #32222 ☐ Gastroscopy # 30473 ☐ Helicobacter test #12533 ☐ Flexi Sig #32084

☐ Other _____

Out of Pocket Expenses/Gaps

The following "Out of Pocket Expenses" relate to the admission and service provided by GIH Access Day Procedure Centre.
They **do not include** any information relating to the medical practitioner fees, anaesthetist fees, pathology fees, pharmacy or transport (private and/or ambulance) as they are not employed by GIH Access Day Procedure Centre. You will receive a separate account from those specialists & service providers. Please discuss the fees associated with those services with the specialists themselves.

Hospital Fee: Total amount to be paid by patient $.....

BSB: 083 547 Acc Number: 879 696 220
Please provide full patient name as reference

Insured patients: GIH Access Endoscopy is a 2nd tier funded facility.
If procedure(s) are alter from your original booking at the time of your procedure additional fees will be incurred, either the balance of your excess or GIH Access agreed procedure fee will apply. If consumables are used fees below will apply.

Consumables: Some items are unknown at the time of providing the pre-procedure financial costs e.g. haemostatic clips for polypectomy. Such items will appear on the account if required.
$100 per clip $80 Oesophageal Dilator $200 Balloon Dilator $50 Tattoo/Ink $60 Polyp $..... Other

To be Completed by the Patient/parent/guardian/legal representative

I, (Print Full Name) _____

(patient,/parent/guardian/ legal representative)

have been fully informed of the GIH Access Endoscopy Day Procedure Centre fees associated with my/the patient's admission, including "Out of Pocket" expenses. I understand and acknowledge that it is my responsibility to confirm with my/the patient's health insurance fund/ insurer the level of cover that I/the patient have/has and any amount that will be my responsibility to pay. I/the patient acknowledge that I/the patient will be financially responsible for payment of any Ambulance transport fees. I acknowledge that the medical practitioners, including the anaesthetist, are not employees of GIH Access Endoscopy Day Procedure Centre, and the fees associated with the attending medical practitioners need to be obtained and discussed with them individually. I have been given ample opportunity to ask any questions I may have regarding fees charged prior to the commencement of the procedure/surgery/treatment, and any "Out of Pocket" expenses. I also understand that in the event of a transfer to another health care service, the expenses and costs associated with that transfer and admission, are mine/the patients, and not that of GIH Access Endoscopy Day Procedure Centre.

Signature of patient,/parent/guardian/ legal representative: _____

Date: _____/_____/_____

If a person other than the patient is to sign this form, relevant formal identity of the person (which includes a photo ID e.g. Driver's licence/ Passport), and their relationship to the patient e.g. Parent/Financial Power of Attorney, must be sighted and a copy attached to this form.