PENNANT HILLS DAY ENDOSCOPY CENTRE

www.pennanthillsendoscopy.com.au

PLEASE CHECK ALL PRINTED DETAILS AND CHANGE ANY INFORMATION SHOWN ON THE LABEL IF NECESSARY

TEL NO: 02 98752311
FAX NO: 02 9980 9300

HOSPITAL ADMISSION

[AFFIX PATIENT LABEL]

DATE OF PROCEDURE: …….

PROCEDURE: Colonoscopy / Endoscopy

Prior to your admission, would you kindly supply the following information **as soon as possible**

HOSPITAL FUND:…… **MEMBERSHIP** NO:…….

Level of cover : Top / Basic- public hospital cover(please circle) **Expiry date**: ……/……..

Have you been a member of the fund for more than twelve (12) months ? ……..

COUNTRY OF BIRTH:…… LANGUAGE SPOKEN …….

(if UK please specify which country)

MARITAL STATUS: …….

Married/Defacto	01
Never Married	02
Widowed	03
Divorced	04
Permanently Separated:	05

INDIGENOUS STATUS: Please circle

Aborigine
Torres Strait
Both
Neither

NEXT OF KIN:(NAME)……..

(ADDRESS)……..

(PHONE)……..... (RELATIONSHIP)…….

HAVE YOU BEEN ADMITTED TO A HOSPITAL WITHIN THE **LAST 28 DAYS** ? ……
IF SO, WHICH HOSPITAL ?…….

ARE YOU **CURRENTLY** AN INPATIENT IN ANY HOSPITAL? IF SO, WHICH HOSPITAL?
……
ARE YOU **ALLERGIC** TO OR HAVE **ADVERSE REACTIONS** TO MEDICATIONS INCLUDING NON PRESCRIPTION AND ALTERNATIVE MEDICINE? …….

DO YOU HAVE ANY MEDICAL CONDITION WHICH DOES NOT ALLOW YOU TO HAVE ***INJECTIONS OR BLOOD PRESSURE*** TAKEN FROM EITHER ARM (EG Lymphodema)
No :…… Yes: (indicate which arm) ……..

ANY SPECIAL DIETARY REQUIREMENTS ?: ……
(ie coeliac, dairy allergies, etc)

Please check your Medicare Number and update where necessary:
MEDICARE NUMBER:…… EXPIRY ……..……
Your reference Number on your Medicare Card: ……

AUSTRALIAN GOVT. PENSION NO: (if any) ……..

REFERRING DOCTOR:……
(**A new referral is required for each twelve month period)**Please return this and the accompanying Medical History Sheet to us **at least 5 days prior to the date of your procedure** either in person, by mail or fax. (02 9980 9300) If you return these papers by fax, please bring originals with you on the day of your procedure.

PENNANT HILLS DAY ENDOSCOPY CENTRE **Name:**

PATIENT HISTORY SHEET **PATIENT LABEL**

DATE OF PROCEDURE:
PROCEDURE: Colonoscopy/ Gastroscopy **Dr:**

Have you had or now have:	*Yes*	*No*		*Yes*	*No*
Asthma or Emphysema			Hepatitis		
Sleep apnoea			Thyroid trouble		
Snoring			Diabetes		
Heart murmur			Previous blood transfusion		
High blood pressure			Women only - Are you pregnant?		
Chest pain, angina			Do you smoke? / per day		
Heart attack (s)			Past history drug abuse		
Palpitations			Do you drink alcohol?		
Stroke			Problems with anaesthetics or sedation?		
Back injury			Any blood relatives with anaesthetic problems?		
Convulsions, epilepsy			Any previous surgery ?		
Anaemia			Any kidney trouble?		
Any other medical history, condition			Have you had Prostate cancer ?		
Jaundice			Have you had Brachy therapy ?		
Rheumatic fever					

If you have answered Yes to any of the above, please give further information:-_____

_____

Are you allergic to drugs, eggs or other substances? Do you have any special dietary requirements? Please list: _____

_____

List all medications you are currently taking, including eye drops and alternative medicines (eg Fish oil; vitamin supplements) :

_____

_____

In the last 6 months have you taken *diabetes medication, insulin, cortisone, steroids, aspirin or blood thinners?* _____

Please explain:_____

Have you been told that you need antibiotics before any medical or surgical procedure? _____

Do you have any chipped or loose teeth, dentures, caps, braces or bridgework? _____

Who is to escort you home? *Name:* _____ *Phone no:* _____

Discharge address (if not home): _____

Emergency contact: _____

I certify the information on this form to be true to the best of my knowledge. I accept full responsibility for accounts rendered by Pennant Hills Day Endoscopy Centre, including any shortfall in reimbursement by my Health Fund / Medicare following settlement by Health Fund / Medicare.
I have had the financial costs of my hospitalisation explained to me and I understand that:

- Total costs cannot be quoted, but only estimated in advance
- My obligation to pay for my hospitalisation is independent of any benefits I may be able to claim from Medicare / Health Fund

Signature: _____ **Date**: _____