Patient Pre-Admission & Registration Form

Have you had a procedure in this building?	**Yes** ☐	**No** ☐
Have you a Latex allergy?	**Yes** ☐	**No** ☐
Do you have Private Health Insurance?	**Yes** ☐	**No** ☐
Are you here due to a recall letter?	**Yes** ☐	**No** ☐

Title: Mr/Mrs/Ms/Miss (circle)

Patient Name: _____ **Date of Birth:** _____

Home Tel Number: _____ **Mobile Number:** _____

Home Address: _____

Suburb: _____ **State:** _____ **Postcode:** _____

Who will be taking you home today? _____

What is the number that we can contact them on? _____

Name of Next of Kin: _____

Relationship: _____

Medicare Number: ☐☐☐☐☐☐☐☐☐☐ **Ref No. eg. 1,2** ☐

Expiry Date: _____

I acknowledge that I have been informed of any out of pocket expenses related to this hospital admission.

I acknowledge that in the event of a polyp being removed, during colonoscopy, I may receive an account. (It is however, in your interest to discuss level rebate with your insurer).

For Metro Spinal patients only - I understand that following my Metro Spinal Clinic procedure it is important to exit the building via the lift and avoid using the stairs.

I am aware of the Patients Rights and Responsibilities brochure and the Complaints/Privacy brochure as displayed at Reception.

IF POSSIBLE PLEASE SEND VALUABLES HOME. A LOCKER WILL BE PROVIDED FOR STORAGE, HOWEVER, NO LIABILITY WILL BE ACCEPTED BY GEDS FOR VALUABLES/JEWELLERY KEPT ON THE PREMISES.

Signature of Patient: _____

GLEN EIRA DAY SURGERY
Tel: (03) 9595 6600 Fax (03) 9595 6611

PRE ADMISSION ASSESSMENT FORM

PATIENT IDENTIFICATION LABEL

PATIENT QUESTIONNAIRE

Do you have?	Yes	No
Heart trouble	☐	☐
Angina	☐	☐
Chest pain	☐	☐
High blood pressure	☐	☐
Breathing trouble	☐	☐
Asthma	☐	☐
Current cold or flu	☐	☐
Diabetes	☐	☐
Do you take insulin?	☐	☐
Epilepsy	☐	☐
History of stroke	☐	☐
Bleeding disorder	☐	☐
Liver disease/hepatitis	☐	☐
Kidney disease	☐	☐
Are you pregnant?	☐	☐
Indigestion/Reflux	☐	☐
Have you or any other member of your family had A history of Creutzfeld Jakob Disease (CJD)	☐	☐
Have you suffered from recent rapid progressive Dementia, the cause of which has not been diagnosed?	☐	☐
Have you received human pituitary hormones (growth Hormones, gonadatrophins) prior to 1985	☐	☐
Have you ever received a Dura Mater Graft?	☐	☐

Please give details: _____

SURGICAL HISTORY

If you have had any previous surgery please give details:

ANAESTHETIC HISTORY—please tick

	Yes	No
Have you had an anaesthetic previously?	☐	☐
Have you or a member of your family had any Problems with anaesthetic?	☐	☐

If yes please comment:

Please specify tobacco usage:
Never smoked ☐ Ex-smoker: when did you quit?_____
Smoker ☐ Cigarettes per day?_____

Please specify alcohol usage:
Not at all ☐ Social/Moderate ☐ Heavy ☐

ALLERGIES

	Yes	No
Do you have any allergies or sensitivities?	☐	☐
Are you allergic to latex?	☐	☐

If yes please provide details, including allergies to any medications, tapes, lotions foods etc: _____

MEDICATION

Please give details of any medication (or attach sheet of any medications) you are taking at the moment (including contraceptive and vitamins).

Name	Dose	Frequency

	Yes	No
Have you had any ASPIRIN in the last week?	☐	☐
Are you on WARFARIN?	☐	☐
Any other blood thinning medication?	☐	☐

RN Signature:_____

PRE-ADMISSION ASSESSMENT FORM MR2