

GLEN EIRA DAY SURGERY Tel: (03) 9595 6600 Fax (03) 9595 6611 Patient Registration Form <u>Please complete all information requested</u>	Patient Identification Label
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Title:		Family Name:			Given Names:			
Home Tel Number:		Mobile Number:			Date of Birth:			
Home address and suburb:								
State and Postcode								
Birth Place:		Marital Status:						
Name and relationship of <u>Next of Kin</u> :					Phone Number of Next of Kin:			
Medicare Number and Ref No. eg. 1,2, (Add numbers to boxes)								Exp Date:
Please complete all the information required:					Yes	No	If yes, provide details	
Have you had a procedure in this building?								
Do you have Private Health Insurance?								
Are you here due to a recall letter?								
Do you have Ambulance cover with Ambulance Victoria?								
Do you have a pension card?								

Discharge Arrangements	
Who will be taking you home today?	What is the number that we can contact them on?

I acknowledge that:

GLEN EIRA DAY SURGERY WILL NOT BE RESPONSIBLE FOR ANY ACCOUNTS FOR AMBULANCE TRANFERS.

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

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).

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

I am aware that Glen Eira Day Surgery may use my personal information to:

- provide the clinical care I require
- administer and manage financial services including charging and billing
- review the clinical care provided as part of the clinical governance program
- monitor the services provided to assist with maintaining and improving the facility
- meet commitments to report mandatory health data to both Commonwealth and State Governments.

A LOCKER WILL BE PROVIDED FOR STORAGE OF PERSONAL ITEMS, HOWEVER, NO LIABILITY WILL BE ACCEPTED BY GEDS FOR VALUABLES/JEWELLERY KEPT ON THE PREMISES.

Occasionally ones teeth may be damaged during the procedure.

For Iron Infusion patients only - the risks of having an iron infusion are: a rash, dizziness, hypersensitivity reactions, myalgia (flu like symptoms), headaches and if infusion extravasates or goes outside the vein it can cause brown discolouration on your skin, which can be permanent.

Signature of Patient:

Patient Registration Form MR 1

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

PRE ADMISSION HEALTH ASSESSMENT

To be completed by the Patient prior to admission:
Date of Completion:

Patient Identification Label, or
Patient should write full name here

Do any of the following apply to you? Please tick the Yes / No box	Yes	No	If yes, provide details
Heart trouble, angina, chest pain, high blood pressure?			
Do you have a pacemaker or other implant inserted?			
Breathing trouble; asthma; current cold or flu?			
Diabetes or do you take insulin? Last BGL result?			
Epilepsy or a history of stroke?			
Dementia; confusion; disorientation			
Bleeding disorder/clotting disorder / DVT?			
Taking Blood Thinning medicines eg Warfarin, Plavix/Iscover, etc			
Have you had any ASPIRIN in the last week?			
Liver disease or hepatitis?			
Kidney disease?			
Indigestion/reflux?			
Surgical History - Have you had any previous surgery?			
Do you have any other Medical conditions?			
Anaesthetic History			
Have you had an anaesthetic previously?			
Have you or a member of your family had any problems with anaesthetic?			
Do you wear dentures or have bridges, caps or crowns?			
Do you smoke cigarettes? If you are an ex-smoker, when did you quit?			Cigarettes per day? _____
Do you drink alcohol?			Social / Moderate /Heavy
Are you pregnant?			
Are you currently menstruating?			
Allergies			
Are you allergic to any medicines?			
Do you have any allergies - food or tapes or Latex etc?			
Do you get hay fever?			

Pre Admission Health Assessment MR11

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Do any of the following apply to you? Please tick the Yes / No box	Yes	No	If yes, provide details
Infection Risk Assessment – Do you have			
Have you been admitted overnight to any overseas health care facility in past 12 months			
Do you currently have symptoms of any respiratory infection (fever, cough) or gastroenteritis (diarrhea/vomiting)?			
Have you been diagnosed with a multi-resistant organism (MRO) or CRE or been identified as a CRE Contact			
Are you currently being treated for any infections?			
Other			
Are you older than 65 years?			
Have you had any falls in last three months?			
Do you use a mobility aid eg frame / stick?			
Do you have any skin conditions / existing wounds / pressure areas / broken skin or reddened skin due to friction or pressure?			
Do you wear glasses or contact lens?			
Do you have difficulty with hearing or speech?			

Ref: Ontario Modified Strategy Sydney Scoring

Are you taking any medicines at the moment?			
If yes, Please give details of any medication (or attach sheet of any medications from your GP that you are taking at the moment (including contraceptive and vitamins)			

Medicine	Dose and frequency	Medicine	Dose and frequency

Pre Admission Health Assessment MR11