The Digestive Health Centre
Pre-admission Assessment and Registration Form

Title **Surname** ……

☐ **Mr** **First Name** ……

☐ **Ms** **Middle Name** ……

☐ **Mx** **Preferred Name** ……

☐ **Mrs** **Pronoun choice** ☐ **he/him** ☐ **she/her** ☐ **they/them**

☐ **Miss**

☐ **Master** ☐ **Other** **Has your surname changed since your last visit** ☐ **Yes** ☐ **No**

Sex ☐ **Male** ☐ **Female** ☐ **Non-binary** ☐ **Other** ☐ **Prefer not to say**

Medicare Number ……Ref No (No. next to name) …… Expiry Date ……

Address …… Postcode ……

Telephone: Home……..Work …… Mobile ……..

Email ……

I understand that by giving my mobile number and email address, I am consenting to receive SMS and emails from The Digestive Health Centre. I also understand that I can choose to "opt out" at any time.

Date of birth: …… Country of birth ……..

Do you identify as being of Aboriginal or Torres Strait Islander origin? Please Circle

No Yes, Aboriginal Yes, Torres Strait Islander Yes, both Aboriginal and Torres Strait Islander Decline to answer

Occupation …….. Language Spoken …… Interpreter required Yes/No

Date of referral …… Referring doctor. ……..

Usual family doctor ……

Is your colonoscopy part of **the National Bowel Cancer Screening Program**? Yes / No

INSURANCE DETAILS

Private insurance □ No □ Yes Name of Fund …… Membership No ……

Work cover □ No □ Yes Insurance co …….. Claim No ……

Veteran Affairs Card No …… Gold / White Pension Card No ……

Health Care Card No …… Expiry date ……

HOW DID YOU HEAR ABOUT YOUR PRACTITIONER?

□GP □ previous patient □Family /friend recommendation □Yellow Pages □White pages
□DHC website □Google □ Bowls club □RSL Club □ Attended a talk □ Local paper

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Next of kin/Emergency Contact …… Relationship……

Contact Home …… Mobile ……

Consent to upload to My Health Record? ☐ Yes ☐ No

Do you have treatment limiting orders? Please provide documentation. ☐ Yes ☐ No

Do you have an Advanced Care Directive? Please provide documentation. ☐ Yes ☐ No

Have you appointed a Medical Treatment Decision Maker (MTDM)? ☐ Yes ☐ No

A MTDM is a nominated person who makes medical treatment decisions on behalf of a person who does not have decision-making capacity.

If No, Under the MTPD Act 2016 the hierarchy system is followed. Spouse, primary carer, oldest adult child, oldest parent, oldest adult sibling

If Yes, please note details below

Name …… Relationship …… Contact number ……

PRE-ADMISSION ASSESSMENT Patient Name: UR: DOB:

☐ Face to Face ☐ Phone Date: Time:	ADMISSION - Date: Time:
Medical History reviewed: ☐ Yes ☐ No	☐ Gastroscopy ☐ Colonoscopy
Further action required: ☐ Yes ☐ No	Comments:

DO ANY OF THE FOLLOWING RELATE TO YOU? (Please tick Yes or No and circle appropriate condition)

	Yes	No		Yes	No
Heart attack / angina / pacemaker / Congenital disease / valve problems/ heart surgery / palpitations			Do you drink alcohol? If yes how many glass/day?		
			Do you use social drugs eg cocaine, marijuana?		
Internal defibrillator			Smoker, if yes, how many/day		
Any other heart condition			Ex smoker		
Diabetes: Diet / Tablets / Insulin			Major Hearing loss		
Cancer			Major sight loss		
Blood clots in legs / lungs			Pregnant or breast feeding		
Asthma / breathing problems eg; shortness of breath/ TB / Sleep apnoea			Is there a family history of bowel cancer / polyps?		
Cold / Flu symptoms Eg; Sore throat/Cough/runny nose/chills or a Chest infection in the past 14 days			Is there a family history of stomach cancer?		
Do you have a blood-borne virus such as HIV, Hepatitis C or Hepatitis B?			Migraines		
Recent loss of sense of smell or taste?			Epilepsy / fits / seizures / faints		
Kidney disease			Intellectual/physical disability requiring carer		
High blood pressure			Have you had any difficulty thinking clearly lately? (With cognitive impairment)		
Stroke			Have you ever been diagnosed dementia?		
Do you take any medications to assist you with your mental health?			Have you ever had an episode of delirium?		
Do you have any current mental health issues?			Weight loss surgery/procedure		
Injectable medications: Ozempic / Mounjaro / Trulicity / Wegovy / Insulin					

PLEASE LIST ALL ILLNESSES, OPERATIONS & MEDICAL CONDITIONS THAT YOU HAVE HAD IN THE PAST.

PLEASE LIST CURRENT MEDICATIONS YOU ARE TAKING INCLUDING INJECTABLE MEDICATIONS –

OZEMPIC/MOUNJARO/TRULICITY/WEGOVY/INSULIN AND OR ANY COMPLEMENTARY/NATURAL MEDICINES

Do you have any allergies? i.e. drugs, tapes, latex, food ☐ Yes ☐ No Comments:
Do you take any tablets to thin the blood? i.e. Warfarin, Aspirin, Plavix, Iscover, Xaralto ☐ Yes ☐ No Comments:
Have you, or any blood relatives, had any problems with general anaesthesia? ☐ Yes ☐ No Comments:
Do you have a history of falls or are you at risk of falls? ☐ Yes ☐ No Comments:
Have you had or been exposed to a person with an infectious disease in the past 14 days? E.g. Chicken Pox, Measles ☐ Yes ☐ No
Have you ever been infected or colonised by MRSA, VRE, CRE/CPE, Norovirus, Clostridium Difficile? ☐ Yes ☐ No
Have you been diagnosed with COVID-19? ☐ Yes ☐ No If Yes; *Date:*
Have you been symptom free for 2 *weeks* post recovery? ☐ Yes ☐ No
Are you a resident of an aged care facility? ☐ Yes ☐ No Comments:

Patient Name:	UR:	DOB:	
Do you have any open wounds, ulcers, cuts, pressure areas, or other skin problems? ☐ Yes ☐ No Comments:			
Do you have any problems lying on your left side? ☐ Yes ☐ No Comments:			
Have you travelled overseas in the past 14 days? ☐ Yes, where? ☐ No Comments:			
Have you had an overnight stay in an overseas residential aged care facility or hospital in the past 12 months? ☐ Yes ☐ No Comments:			
Do you have any objection to receiving blood or blood products? ☐ Yes ☐ No Comments:			
Weight_____(kg) Height_____(cm)			
Alerts ☐ Yes ☐ No DOCUMENT ON ALERT FORM			
NURSING ASSESSMENT SUMMARY INDICATION:			
Prep Given:	BGLs:	BMI:	Reflux:
PPI:	FHx:		Signature:
Discharge/Carers Instructions/Responsibilities explained and given to patient:			☐ Yes ☐ No
Morning medications discussed			☐ Yes ☐ No
Comments:			

PRIVACY COLLECTION STATEMENT

DANDENONG GASTROENTEROLOGY PTY LTD ACN 080 857 549 AS TRUSTEE FOR THE DG UNIT TRUST ("The Digestive Health Centre") collects your personal information for purposes related to (or in the case of sensitive information, directly related to) our functions or activities, including facilitating the delivery of health services to you from your health practitioner, informing you of services which may be relevant to you and to communicate with you on behalf of your health practitioner. We may not be able to facilitate the delivery of health services from your health practitioner to you if you do not provide this information. Your personal information may be disclosed to our related bodies corporate, health practitioner, and third-party services providers. Your personal information is kept private and secure, as required by federal and state privacy laws. Please refer to our Privacy Policy for full details of how we handle your personal information, including how you may access and seek correction of your personal information, complain about a privacy breach, and how we will deal with that complaint.

PERSONAL INFORMATION CONSENT

In accordance with section 6(1) of the *Privacy Act 1988* (Cth) (**Privacy Act**), all information collected in this medical practice is treated as 'sensitive information'. To protect your privacy, DANDENONG GASTROENTEROLOGY PTY LTD ACN 080 857 549 AS TRUSTEE FOR THE DG UNIT TRUST ("**The Digestive Health Centre**") operates in accordance with the Privacy Act and its Privacy Policy. A copy of our Privacy Policy is available free of charge from reception or on our website Privacy Policy – Digestive Health Centre.

Your health practitioner uses the information you provide to manage your health care, which may include using the information for the following purposes (including instructing The Digestive Health Centre to use the information for the following purposes on your health practitioner's behalf):

1. Collecting, recording and storing your personal and health information that will form part of an individual computerised medical record.
2. Issuing reminders for specific health checks that you may require, if any, as part of your consultation with your health practitioner and/or nurse.
3. Providing you with health information updates, general medical updates and provide your personal and health information to the relevant state and/or national recall reminder registers.
4. Using your personal and health information to undertake, however not limited to; administrative tasks involved in the running of the The Digestive Health Centre, and for your health practitioner, billing tasks which includes compliance with Medicare, Health Insurance Commission and other relevant Government agency requirements.

You can assist in maintaining the accuracy of your information by advising your health practitioner or reception of changes in your contact details.

Selected information may be disclosed to various other health care providers involved in supporting your health care management (e.g. pathology and imaging providers, hospitals or other specialists). You hereby acknowledge and consent to the disclosure and/or use of your personal health information by The Digestive Health Centre, your health practitioner and persons directly or indirectly involved in your personal health care or medical treatment for that purpose, including:

1. Sending specimens obtained from you to the necessary pathology provider for analysis. As a result, you understand that you may incur an out-of-pocket expense, by which a separate invoice will be issued by the relevant pathology provider. You understand that you will be liable for all expenses incurred.
2. Disclosing your personal and health information to the relevant medical and allied health service providers involved in your care.
3. Disclosing de-identified personal and health information for research and quality assurance purposes undertaken by your health practitioner to improve the quality of both individual and community health care needs and medical practice management. The Digestive Health Centre will inform you when such activities are being conducted and give you the opportunity to 'opt-out' of any involvement at any time.
4. Using your personal and health information by your health practitioner and other authorised individuals involved in your medical care and treatment, both directly and indirectly.
5. Disclosing for legal related purposes as requested and required by a court or other regulatory body.
6. For medical training/teaching purposes where de-identified information is disclosed to medical students and staff.
7. For disease notification as required by the law.

You are not obliged to provide information requested of you, however your failure to do so may compromise the quality of care provided to you by your health practitioner.

You understand your right to access both your personal and health information held by The Digestive Health Centre, except in circumstances where access is legitimately withheld. If your personal and health information is to be used for any other purpose, other than what is set above, your further consent will be obtained.

You understand it is your responsibility to inform The Digestive Health Centre at the earliest of any changes to your personal and health information. If any information held about you is inaccurate, you may request to have this altered accordingly.

You hereby acknowledge and consent to the disclosure and/or use of your personal health information by The Digestive Health Centre on your health practitioner's behalf and persons directly or indirectly involved in your personal health care or medical treatment for the purposes set out above.

If you have any questions regarding the management of your personal health information or need to arrange to access to your records, please ask reception or your health practitioner, as appropriate.

Please sign this form as confirmation that you have read and understood the above mentioned and consent to the use of your personal and health information as stated above.

Signature:…… Name:……. Date: ……/…….. /20……

If you do not wish for this to occur, please advise reception or your health practitioner

Patient Name: UR: DOB: