Ulladulla Endoscopy and Medical Centre

111 Princes Highway,
PO Box 110, Ulladulla, 2539
Tel: 02 4455 5422, Fax: 02 4454 2263
www.ulladullaendoscopy.com.au

PATIENT DETAILS AND CONSENT FORM

Section A: Personal Details

Title	Surname	Given Names

Gender	Date of Birth	Marital Status
Male/Female	/ /	Single/Married/De Facto/Separated/Divorced/Widowed

Home Address	Post Code

Postal Address	Post Code

Telephone Number	Work Number	Mobile Number
( )	( )	

Email

Medicare Card No	Medicare Reference No	Medicare Card Expiry Date
		/

Pension/Health Care Card or Veterans Affairs No (if applicable)	Type of Veterans Affair Card	Expiry Date

Health Fund Name	Membership Number	Level/Excess if known

Occupation

Who can we contact in the event of an emergency?	
Name	Relationship to you

Telephone Number	Work Number	Mobile Number
( )	( )	

Do you have an Advance Health Directive for end of life care? For more information please talk to your GP	Yes	No

Section B: Cultural Background

Knowing your cultural background can help us provide healthcare that meets your individual needs.

Country of Birth			**Other cultural background (eg, Mediterranean, Asian, African)**			
Is English your first language?	Yes	No	**If not, do your require an interpreter?**	Yes	No	**Please specify language**
Are you of Aboriginal or Torres Strait Islander origin?					**Yes**	**No**
Aboriginal		Torres Strait Islander		Aboriginal and Torres Strait Islander		

Section C: Consent

Our practice uses a reminder system to help you maintain your health. The practice sends reminders by post, telephone or SMS for procedures such as blood tests, vaccinations and others. Our practice also sends information to the Australian Childhood Immunisation Register and Pap Smear Register. These registers also send reminders.

I consent to being contacted with reminders to help me maintain my health:	Yes	No

This practice collects information from you for the primary purpose of providing quality health care. In keeping with the *Privacy Act 1988* and *Australian Privacy Principles*, we wish to provide you with sufficient information on how your personal information may be used or disclosed.

By signing below, you (as a patient/parent/guardian) are consenting to the collection of your personal information, and that it may be used or disclosed by the practice for the following purposes:

- Administrative purposes in running our practice.
- Billing purposes, including compliance with Medicare requirements.
- Follow-up reminder/recall notices for treatment and preventative healthcare.
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.
- Accreditation and quality assurance activities to improve individual and community health care and practice management.
- For legal related disclosure as required by a court of law.
- For the purposes of research only where de-identified information is used.
- To allow medical students and staff to participate in medical training/teaching using only de-identified information.
- To comply with any legislative or regulatory requirements e.g. notifiable diseases.
- For use when seeking treatment by other doctors in this practice.

Signature of patient or guardian	**Date** / /
If not patient signing – Your Name	**Relationship to patient**

We aim to protect the privacy and secure storage of your health information. You can request a copy of our Privacy Policy from one of our Reception Staff. This Policy includes information about the collection, use and disclosure of your health information.

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PRE-OPERATIVE QUESTIONNAIRE

Name: _____ DOB: _____

General Practitioner: _____ Location: _____

Health Insurance? Yes/No Pension? Yes / No

What procedure do you need? Gastroscopy / colonoscopy / hemorrhoids / unsure / other _____

What are your symptoms / why do you need this procedure? _____

_____

General	YES	NO
1. Do you have any allergies? (list the type and reaction)	☐	☐
2. Do you (or have you ever) smoke? If yes, how many per day? ☐ ex-smoker	☐	☐
3. Do you drink alcohol? (how many / how often)?	☐	☐
4. Do you have an advanced care directive (living will) or "power of attorney" in place? If yes, please provide us a copy on or before your procedure date	☐	☐
5. Do you have dentures, crowns, or loose teeth?	☐	☐
Cardiovascular Risk	**YES**	**NO**
6. Do you have any heart trouble,eg: chest pain, heart attacks, stents, AF, heart murmur, artificial heart valve, heart operations, pacemaker, or heart defects?	☐	☐
7. Do you have high blood pressure or other blood pressure problems?	☐	☐
8. Do you have breathing problems, eg: Asthma, Bronchitis, Emphysema, chronic cough, shortness of breath or other issues?	☐	☐
9. Can you walk up 10 stairs without stopping?	☐	☐
Health Screening	**YES**	**NO**
10. Do you have diabetes? If yes, what type?	☐	☐
11. Do you have thyroid disease?	☐	☐
12. Have you had a stroke or TIA?	☐	☐
13. Do you have a seizure disorder or epilepsy?	☐	☐
14. Do you have any other serious illnesses? If yes, please provide details	☐	☐
15. Are you currently pregnant or breastfeeding?	☐	☐

Previous Procedures	YES	NO
16. Have you had any previous surgeries? If yes, please provide details	☐	☐
17. Have you or anyone in your family had anaesthetic problems? If yes, please provide details	☐	☐
18. Have you had any endoscopic procedures in the past, eg gastroscopy, colonoscopy?	☐	☐
19. Do you have any family history of bowel cancer or bowel polyps?	☐	☐
20. Do you have any joint replacements or metal plates / screws in your body?	☐	☐
Falls Risk	**YES**	**NO**
21. Do you use a walking stick or walking frame?	☐	☐
22. Do you get dizzy or lose balance easily?	☐	☐
23. Do others tell you that you are unsteady on your feet?	☐	☐
24. Do you take medication that leaves you disorientated?	☐	☐
25. Have you had a fall in the last 3 months?	☐	☐
Pressure Injury Risk	**YES**	**NO**
26. Have you ever had a pressure injury or bed sore?	☐	☐
27. Do you find that your skin bruises or tears easily?	☐	☐
28. Do you require assistance to change position or get in and out of a chair or bed?	☐	☐
29. Do you currently have anaemia?	☐	☐
Infection Risk	**YES**	**NO**
30. Do you have an artificial heart valve, heart murmur or recent surgery?	☐	☐
31. Do you have hepatitis or HIV?	☐	☐
32. Have you ever had MRSA, Golden Staph, C. Difficile diarrhoea, CRE or VRE?	☐	☐
Bleeding Risk	**YES**	**NO**
33. Are you on Warfarin, Plavix, Xarelto, Pradaxa, Cartia or other blood thinners?	☐	☐
Medications	**YES**	**NO**
34. Do you take any regular medications? If yes, please list them including dose and frequency	☐	☐