

PATIENT IDENTIFICATION LABEL

Staff to tick & initial to indicate Clinical Handover at Point of Care	From: Reception	To: Admission Nurse
Patient ID& Procedure Match		
Alerts		
Medicare status		
Special requirements-including language		
<i>Initial to indicate Clinical Handover at this Point of Care</i>		

PATIENT ADMISSION DETAILS

Admitting Doctor/Surgeon:

Date of Admission:

Arrival Time (Office use only)

Discharge Time (Office use only):

Operation/Procedure:

Have you been hospitalized anywhere in the last seven days? Yes ☐ No ☐ If yes, where

PATIENT DETAILS — Please print as your name appears on Medicare Card

Title:	Surname:	Previous Surname:
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Given Name:

Address:	Postcode:
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Phone (H)	(M)	(B)
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Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>	Date of Birth:	Marital Status:
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Country of Birth (if Australia, which state)	Are you an Australian Resident? Yes <input type="checkbox"/> No <input type="checkbox"/>
Religion:	Are you of Aboriginal/Torres Strait Island Descent? Yes <input type="checkbox"/> No <input type="checkbox"/>

Medicare number:	Reference No:	Expiry Date:	Ambulance Membership Number: Y/N
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Pension No.	Expiry Date:
Health Care Card	

Private Health Fund:	Membership Number:
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Next of KIN (Person to contact in case of Emergency)

Name:Relationship:
Contact No.

ESCORT CONTACT DETAILS (who will be taking you home?)

Name:Relationship:
Contact No.

Charter of Rights:

I have read and understand my rights as per Rights & Responsibilities Information provided by IVE

Patient Signature:

PRE-ANAESTHETIC ASSESSMENT

Patient to complete. Admission Nurse to review with patient at time of pre-operative assessment, then handover to Doctors prior to consultation.

1. Medical History

Have you ever had any of the following complaints?

	Yes	No
High Blood Pressure		
Heart Attack		
Angina		
Stroke		
Rheumatic Fever		
Blood clot in legs or lungs		
Kidney Disease		
Diabetes	Type 1/ Type 2	
Anaemia		
Pneumonia or Tuberculosis		
Hepatitis or Jaundice		
Eczema		
Hay Fever		
Nervous Breakdown		
Epilepsy or fitting		
Prosthetic Joints		
Heart Valve Replacement		
Recent Cold		
Other serious illness		

If yes to any of the above please give details:

2. Surgical History

Have you had any previous operations? Yes No

Details:

Operation	Year

	Yes	No
Have you got bleeding tendency?		
Do you bruise easily?		
Have you had blood transfusions? Date: ____		
Any reaction to transfusion?		

Have you had blood thinner in the past week? Yes No

Time of last food: _____ **Time of last drink:** _____

Height: _____ Weight: _____

Nursing Notes:

Nurse Name: _____ **Date:** _____

Staff to tick & initial to indicate Clinical Handover at Point of Care	From: Admission Nurse	To: Doctors
Patient ID & Procedure Match		
Alerts		
Fasted/Preparation completed correctly		
Relevant Medical History		
Special requirements-including language/translator		
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3. Anaesthetic History

Have you or a family member had an anaesthetic complication?

Yes No

Details: _____

4. Medications

Please list your current Medications

5. Allergies

Do you have any allergies? Yes No

If Yes, _____

6. Other:

	Yes	No
Do you smoke?		
How Many?		
Do you drink Alcohol?		
How much per day?		
Have you used intravenous drugs?		
Do you have a history of infectious disease (i.e. AIDS, HIV, Hepatitis, TB etc)?		
Do you have a family history of CJD (Creutzfeldt-Jakob disease)?		
Have you had a recent hospital stay?		
Have you had a temperature in last week?		
Females, Are you Pregnant?		
If Yes, EDC		
Do you require any assistance with mobility or use any aids such as walking stick, frame?		
Do you have any issues with skin integrity such as ulcers, skin tears, lesions or wounds?		
Do you require assistance to communicate? Hearing or vision deficit, cognitive impairment?		
Do you require an interpreter? If so what language?		

PATIENT ID LABEL

**PATIENT IDENTIFICATION LABEL**

The answers I have given to all questions are true to the best of my knowledge and I have not withheld any information. Following surgery I will have a responsible adult to drive me home. I realize that mental impairment may persist for several hours following the administration of anaesthetic. I will avoid making decisions or taking part in activities which may depend upon full concentration or judgement for 24 hours.

PATIENT VALUABLES CONSENT

Ivanhoe Endoscopy Centre (IVE) requests patients to give all valuables (including wallet, jewellery, mobile phone, etc) to family or friends before admission for safe keeping. Patients are kindly advised that Ivanhoe Endoscopy Centre is not responsible for any damage or loss to any items belonging to patients.

Consent (A)

I agree with the above valuables policy and have handed all valuables to my family or friend.

Signature of Patient

Date

OR

Consent (B)

I agree with the above valuables policy but have decided to keep all valuables myself during admission and that Ivanhoe Endoscopy Centre is not responsible for any damage or loss to any of my belongings. I further agree to turn off my mobile phone for the total duration of my admission.

Signature of Patient

Date

PATIENT FINANCIAL CONSENT

I am aware that I am liable to pay \$ _____ theatre fee prior to admission +/- \$ _____ after procedure. I am also aware that should my preparation deemed to be insufficient and needed to have a repeat I am to pay fees once again. Also, in the event an ambulance is required to transfer me to another facility I am aware that I am responsible for the ambulance fee.

Signed: _____

Witness Signature: _____

Print Name: _____

Print Name: _____

Date: _____

Date: _____