Centre for Digestive Diseases
The Centre of Excellence in Gastroenterology

Level 1, 229 Great North Road,
Five Dock, NSW 2046
Phone: 61 2 9713 4011
Fax: 61 2 9712 1675
Web: **www.cdd.com.au**

PATIENT REGISTRATION FORM

IMPORTANT:
Please complete this form & return it to CDD with your doctors referral attached 2 WEEKS prior to your procedure date, to avoid rescheduling orcancellation of your booking.

Personal Details

Surname: _____

Given Name/s: _____

Address: _____

_____ Post code: _____

Date of Birth: _____ Sex: _____

Marital Status:_____ Occupation: _____

Home Phone: _____ Work Phone: _____

Mobile no: _____ Religion: _____

Email Address: _____

Country of Birth: _____

Language Spoken: _____

Please produce valid card on admission

Medicare Number: __ __ __ __ __ __ __ __ __ __

Expiry: __ __ / __ __ __ __

No. Next to given name: _____

Reciprocal card: ☐ YES ☐ NO

Next of Kin

Name: _____

Contact details: _____

Relationship to patient: _____

Financial Details

☐ Private Health Fund (fill in Section 1)

☐ Pension / Health Care Card (fill in Section 2)

☐ Veterans Affairs Card (fill in Section 3)

☐ None if the above (read Section 4)

☐ No Medicare / Overseas patient (read Section 5)

- *I agree and accept responsibility for the charges levied by the Centre for Digestive Diseases for theatre, accommodation and medical consultations. I acknowledge that there may be further charges for disposable items used during my procedure which cannot be foreseen.*
- *I agree to the Centre for Digestive Diseases accessing all relevant infomation about my medical condition or history from other health care providers. I understand that to provide the highest quality medical care, my clinical records may be accessed and reviewed by staff of this practice and, in some circumstances other health care providers.*

Patient Signature: _____ *Date:* _____

Procedure: _____

Proceduralist: _____

Procedure Date: _____

Have you been admitted here previously? ☐ YES ☐ NO _____ YEAR

Referring Doctor Name: _____

Telephone Number: _____

Section 1 – Health Fund Details

Name of Health Fund: _____

Membership no: _____

Please note: CDD will check your level of health fund cover prior to your procedure. However, it remains your responsibility to pay any out-of-pocket expense or health fund excess on the day of the procedure.

Section 2 – Pension / Health Care Card

Please produce valid card on admission

Pension No.: _____ Exp date: _____

HCC No.: _____ Exp date: _____

Please note: As a pension card / HCC holder, all doctors fees will be bulk billed. However, there will be expenses not covered by Medicare for theatre and accommodation. You will be advised of the approximate cost prior to your procedure – this is payable on the day of your procedure.

Section 3 – Veterans Affairs Card

Please produce valid card on admission

Card Number: _____

☐ White Card ☐ Gold Card

Section 4 – Uninsured Patients

*CDD is a **PRIVATE** Day Hospital. You will need to pay expenses not covered by Medicare for doctors fees, theatre and accommodation. You will be quoted an approximate cost for your procedure – this is payable on the day of your procedure.*

Section 5 – No Medicare / Overseas Patients

You will need to pay the full cost for Doctors fees, theatre and accommodation. You will be quoted an approximated cost prior to your procedure – all fees are payable on the day of the procedure.

Office use only
Patient estimate:

Reception sign: Date given:

48 hours notification is required for Procedure Cancellation or a $200.00 Cancellation Fee will be charged

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PATIENT LABEL

PATIENT MEDICAL HISTORY

Complete and return with the Pre Admission form

Procedure to be performed:

Date ___/___/___ ☐ **Panendoscopy** ☐ **Colonoscopy** ☐ **Other:** _____

1. GENERAL HEALTH

- ☐ Heart Problems
- ☐ Pacemaker/Implants
- ☐ High Blood Pressure
- ☐ Stroke/Blood Clots
- ☐ Bleeding/Blood Disorder
- ☐ Thyroid Disorders
- ☐ Asthma/Lung Disease
- ☐ Heartburn/Reflux
- ☐ Advanced Care Directive
- ☐ Arthritis
- ☐ Diabetes ☐ Type 1 ☐ Type 2
- ☐ Hepatitis/Liver Disease
- ☐ Epilepsy, last fit _____
- ☐ Tuberculosis
- ☐ Kidney/Bladder Disease
- ☐ Sleep Apnoea
- ☐ Wounds/Breaks in skin
- ☐ Treatment Limiting Order
- ☐ Do you smoke?
- ☐ Have you ever smoked? Date ceased ____ / ____ / ____
- ☐ Are you pregnant?
- ☐ Significant Infection Eg. MRSA, VRE
- ☐ Recent Respiratory Infection Eg. Cold, Flu
- ☐ Travel overseas in the last 14 days
- ☐ Hearing Loss
- ☐ Walking Aids
- ☐ Recent Dental Work
- ☐ Any other serious illness

If any of these boxes have been ticked, please provide further information:

If you have a special diet please bring your own food for after the procedure.

Weight: _____ kg Height: _____ cm

2. ALLERGIES / PAST HISTORY

Please list allergies/adverse reactions (including foods,medication, latex etc)	Please list major operations and dates (include all operations within the last six months)

Have you or your family ever experienced problems with anaesthetic? ☐ Yes ☐ No Specify: _____

3. MEDICATIONS

Please list current medications (including HRT, the pill, complementary therapies)

Are you currently or have you within the last 12 months taken Warfarin/Plavix blood thinning medication? ☐ Yes ☐ No

If Yes, have you been instructed to cease this medication? ☐ Yes ☐ No Date last taken ___/___/___

4. DISCHARGE PLANNING

You must have someone to take you home. You should have someone with you overnight.

PLEASE ATTACH DOCTORS REFERRAL TO THESE FORMS

ACKNOWLEDGEMENT OF PATIENT MEDICAL HISTORY

The information in the "Patient Medical History" section above that I have given, is true to the best of my knowledge. I understand that I will be unfit to drive until the day after the procedure and will make alternative travel arrangements.

I also give my consent to the Centre for Digestive Diseases to release all information concerning my condition, treatment and personal details to my General Practitioner, my Medical Insurer and any Medical Specialist that my Endoscopist refers me to for further treatment or medical opinion in accordance with the Privacy act 2002, HRIPA ACT.

Signature: _____ Print Name: _____ Date: _____

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ADDITIONAL PATHOLOGY FEES

Name

Dear Sir/Madam,

Please note that the Gastroenterologist performing your procedure may request Pathology services i.e.: Blood test, Biopsies, cultures etc.

The following tests are sent out to **various pathology companies** according to the test required therefore you may receive accounts from more than one company. Unfortunately we are unable to predict what tests will be required until the procedure is carried out.

Not all tests requested are a Medicare rebatable item and may incur additional costs to you.

NB : PATHOLOGY EXPENSES WILL BE YOUR RESPONSIBILITY.

The Pathology companies are not owned by CDD and all queries relating to their accounts must be directed to them.

Signature **Date**

NB: Please return this form together with registration form, patient medical history form as well as Doctors' referral in the reply paid envelope provided.