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 doctor's referral attached 2 WEEKS prior toyour 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: _____

Indigenous Status: ☐ Aboriginal

☐ Torres Strait Islander

☐ Neither ☐ Decline to answer

Do you live alone? ☐ YES ☐ NO

Are you a sole carer for someone else? ☐ YES ☐ NO

**Please produce valid card on admission**

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

Expiry: __ __ / __ __ __ __

No. Next to given name: _____

Reciprocal card: ☐ YES ☐ NO

☐ No Medicare / Overseas patient

## Next of Kin

Name: _____

Contact details: _____

Relationship to patient: _____

*• 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, and as required by law. I understand that my information will be handled in accordance with the Privacy Act 1988 and relevant amendments.*

*Patient Signature:* _____ *Date:* _____

Procedure: _____

Proceduralist: _____

Procedure Date: _____

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

Referring Doctor Name: _____

Telephone Number: _____

## Health Fund Details

Name of Health Fund: _____

Membership no: _____

***Please note: We will check your level of health fund cover prior to your procedure. We advise you also check with your insurer to make sure you are covered for this procedure and to confirm any gap payments. It is your responsibility to pay any out-of-pocket expenses or health fund excess on the day of the procedure***

## 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.***

## Veterans Affairs Card

**Please produce valid card on admission**

Card Number: _____

☐ White Card ☐ Gold Card

## 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.*

## 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 Cancellation Fee will be charged.**



RESET FORM

# OFFICE USE ONLY

## - Health Fund Queries -

**Fund Check Done: Date** _____ / _____ / _____ **Name:**

**Method (circle): Internet (attach printout)**

**Phone • Fund Contact**

**Fax • returned before procedure date? YES / NO - Complete Financial details**

**Financial? YES / NO - Complete comments section**

**In fund for more than 12 months? YES / NO - Complete comments section**

**Excess? YES $** **NO**

**Excess paid this year? YES / NO**

Initials

**Comments (Initial all comments):**

**Calculations**

**Initials and date**

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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
- ☐ Advance Care Directive
- ☐ Arthritis
- ☐ Diabetes ☐ Type 1 ☐ Type 2
- ☐ Hepatitis / liver disease
- ☐ Epilepsy, last seizure _____
- ☐ Tuberculosis
- ☐ Kidney / bladder disease
- ☐ Sleep apnoea
- ☐ Wounds / breaks in skin
- ☐ Current smoker
- ☐ 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
- ☐ Dementia / delirium
- ☐ Mental health condition eg. anxiety / bipolar
- ☐ 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

| | |
|---|---|
| **ALLERGIES**<br>Please list allergies/adverse reactions (including foods,medication, latex etc) | |
| **PAST HISTORY**<br>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**

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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.**





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