



PATIENT REGISTRATION FORM

IMPORTANT

Please complete this form & return it to CDD with your doctor's referral attached 2 WEEKS prior to your procedure date, to avoid rescheduling or cancellation of your booking.

Personal Details

Title: Mr / Ms / Miss / Mrs / Dr _____

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: _____

Privacy Consent

I agree to the Centre for Digestive Diseases accessing all relevant information 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 including the My Health Record System. I am aware that AI may be used during my care. 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: 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.

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.
Please email the completed registration form to RECEPTION@CDD.COM.AU



PATIENT MEDICAL HISTORY

Complete and return with the Pre Admission form

Procedure to be performed:

Date **Panendoscopy** **Colonoscopy** **Other:** _____

1. GENERAL HEALTH

- | | | |
|--|---|--|
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Diabetes <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 | <input type="checkbox"/> Are you pregnant |
| <input type="checkbox"/> Pacemaker/Implants | <input type="checkbox"/> Hepatitis / liver disease | <input type="checkbox"/> Significant Infection Eg. MRSA, VRE |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Epilepsy, last seizure _____ | <input type="checkbox"/> Recent respiratory infection eg. cold, flu |
| <input type="checkbox"/> Stroke/Blood Clots | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Travel overseas in the last 14 days |
| <input type="checkbox"/> Bleeding/Blood Disorder | <input type="checkbox"/> Kidney / bladder disease | <input type="checkbox"/> Hearing loss |
| <input type="checkbox"/> Thyroid Disorders | <input type="checkbox"/> Sleep apnoea | <input type="checkbox"/> Walking aids |
| <input type="checkbox"/> Asthma/Lung Disease | <input type="checkbox"/> Wounds / breaks in skin | <input type="checkbox"/> Recent dental work |
| <input type="checkbox"/> Heartburn/Reflux | <input type="checkbox"/> Current smoker | <input type="checkbox"/> Dementia / delirium |
| <input type="checkbox"/> Advance Care Directive | <input type="checkbox"/> Have you ever smoked | <input type="checkbox"/> Mental health condition eg. anxiety / bipolar |
| <input type="checkbox"/> Arthritis | Date ceased ____ / ____ / ____ | <input type="checkbox"/> 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 Please list allergies/adverse reactions (including foods, medication, latex etc)	
PAST HISTORY 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

Are you on any weight loss/diabetes medication (e.g. Ozempic, Mounjaro, Wegovy) 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



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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Dr. Simon Benstock
215156AA

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Prof. Shanmugarajah Rajendra
278837PW

Dr. John Saxon
009826FJ

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065080DA

Prof. Robert Clancy
029209EH

Dr. Sanjay Ramrakha
58822EW

Dr. Anis Yusuf
204364EH

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487306CY