ENDOSCOPY & COLONOSCOPY ADMISSION FORM

Screened pre-op ☐

Suite 202/20 Bungan St
Mona Vale, 2103
(ph) 02 9979 3888
(f) 02 9979 3066
(e) admissions@pittwaterdaysurgery.com.au

Please complete this form ASAP and return to PDS at least 7 days prior to your procedure date

Operation Date:............/ .... / .... Surgeon:..

Admitting Diagnosis ....

Planned Procedure ....

....

.... GA / LA / Sedation / Nil

Corresponding Item Numbers..

Patient Name:

Mr. Mrs. Ms. Miss. Master ....

D.O.B. ..../ .... /.............. Age .... Sex ❑M ❑F ❑Other

Address: .... Post Code:..................................

Phone: (H).. (W) .... (M)..

Email:..

Marital Status: ❑Child ❑Single ❑Married ❑Widow ❑Separated ❑Divorced ❑Defacto

Country of Birth:.. Language spoken at Home: ....

Occupation:.. **Referred by Dr**..

Aboriginal: ❑Yes ❑No Torres Str. Is. ❑Yes ❑No I decline to answer ❑

Next of Kin:.. Relationship:.................................... (Ph) ....

Do you have an Advanced Care Directive or Treatment Limiting order? ❑Yes ❑No A copy is required if applicable

Health Fund Details – To be completed by Patient and Office staff

Medicare No:.......................................Line reference:........ Exp Date: .... DVA No ....White / Gold

Health Fund:.. Membership No:.................................. Co-payment/ Excess................................

Financial ❑Yes ❑No Fund Check .... (Initial) Uninsured fee on admission ....

Patient Consent – To be completed by Patient / Parent or Legal Guardian

I,.., request, understand and consent that the following procedure be performed ....

I accept the professional opinion of Dr. ....that this is the appropriate procedure/treatment for my condition.

- ❑ I have received written information about the preparation, procedure, the anaesthetic and post procedure care.
- ❑ I accept the possible risks associated with this procedure/treatment and the required preparation. I have had the opportunity to ask questions and I am satisfied with the explanation and the answers given to me.
- ❑ I agree to such further or alternative treatment as may be found necessary in relation to the procedure.
- ❑ I also consent to the administration of anaesthetics, medicines, or other forms of treatment associated with this operation/procedure.
- ❑ I understand that drowsiness may persist for several hours after sedation. I will not drive a car, or drink alcohol and will avoid making important decisions (e.g. signing of legal documents) for 24 hours following procedure.
- ❑ Following the procedure I will have a responsible adult to accompany, supervise my return home and will stay overnight to safeguard my safety.
- ❑ I understand that I may withdraw my consent at anytime prior to the procedure and/or treatment.
- ❑ (If required); I do not consent to: ☐ Blood Transfusion

....
Practitioner acknowledgment / Signature required

Signature of Patient / Guardian .... Date ....

DO NOT WRITE IN THIS BINDING MARGIN

Pittwater
Day Surgery

Medical History Questionnaire

Patient name ....
D.O.B ..../ ..../ ....
MRN ....
Surgeon...
Admission Date................../................/ ....
Please affix PDS patient label here

Medical History	Yes	No	N/A
Problem with Anaesthetics General / Local			
Family history of Anaesthetic Problems			
Diabetes – Type 1 or Type 2?			
Asthma / Lung Disease/ Shortness of Breath			
Sleep Apnoea / CPAP			
Reflux or Indigestion			
Cardiac Disease / Cardiac surgery / Chest Pain			
High Blood Pressure / irregular heartbeat			
Any Back or Hip problems?			
Rheumatic fever			
Stroke / chronic or degenerative illness			
Epilepsy / Parkinsons disease?			
Do you have any surgical implants? eg pacemaker, cochlea implant, joint replacement			
Could you be pregnant?			
Do you currently smoke?			
Have you ever smoked?			
When ceased?			
Do you drink alcohol? /day			
Weight kgs			
Height cms			

	Yes	No	N/A
Have you been overseas in the last 6 weeks or been in an overseas hospital in the past 12 months?			
Have you had a cold/flu in the past 2 weeks?			
Have you taken steroids / Cortisone in last 6 months?			
Do you take any blood thinning medications? E.g. Aspirin, Warfarin, Viagra/Plavix?			
Have you had anaemia or a blood transfusion?			
Do you have bleeding or clotting tendencies?			
Have you been exposed to any communicable illnesses? E.g. MRSA, CRE, VRE			
Do you have HIV, Hepatitis?			
Have you been investigated for CJD exposure?			
Do you have a history of mental illness e.g. anxiety, depression, dementia or delirium?			
Have you recently undergone a cognitive assessment?			
Do you live alone?			
Are you a sole carer?			
Are you unsteady & use a walking frame/ stick? Have you had a recent fall?			
Do you suffer from compromised skin integrity?			
Do you have any skin tears?			

If you answered YES to any of the above, please provide details here or on a separate page

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Allergies & associated reactions ....

Sensitivities? ....

Previous Operations/ Hospitalisations ....

....

Current medications ....

....

Vitamins & herbal supplements...

Please ask your GP for a copy of your medication regime and bring this with you on admission (if applicable)

Privacy: Pittwater Day Surgery acknowledges its obligations to you under the Privacy Act 1988 as amended. Please forward any concerns / complaints to the Director of Nursing for Pittwater Day Surgery or the Health Care Complaints Commission (Toll Free) 1800 043 159; www.hccc.nsw.gov.au