

PATIENT TO KEEP

Please detach this page and retain for your reference.

Welcome and thank-you for choosing one of our facilities for your gastrointestinal procedure.

Our team of dedicated staff are committed to providing our patients with the highest possible care. We hope your stay with us is as comfortable and as pleasant as possible.

You have been asked to attend one of our two Day Hospital facilities:

- Chermside Day Hospital or
- Brisbane Endoscopy Services (Sunnybank)

Admission process

Please read this form carefully and follow the instructions.

- READ pages 1–2. These pages are for your information and to keep for future reference. *Please detach.*
- COMPLETE pages 3–6 of this booklet. This information details both your personal and medical history which as a facility we are required to know.

Colonoscopy patients

- For those patients who are referred into our facility by a GP and are not required to see a Gastroenterologist prior to your procedure, please bring pages 3–6 (completed) with you when you attend for your preparation appointment (prep kit appointment).
- If you are a patient of one of our Gastroenterologists (i.e. you have had a consultation with a Gastroenterologist or booked your procedure through their private practice) and you are attending one of our facilities for a prep kit, then please bring pages 3–6 (completed) with you to your prep kit appointment.
- If you are receiving the prep kit through your Gastroenterologist's private rooms, then please post or fax pages 3–6 (completed) to the facility where you are to have your procedure.

Upper Endoscopy patients

- Unless otherwise advised please post or fax pages 3–6 (completed) to the facility where you are to have your procedure performed. If time does not allow, then please bring pages 3–6 (completed) with you on the day of your procedure.

CHERMSTIDE DAY HOSPITAL

Level 1, Chermside Medical Complex
956 Gympie Road, Chermside QLD 4032

Bookings: (07) 3120 3407 or (07) 3120 3408

Fax: (07) 3120 3443

BRISBANE ENDOSCOPY SERVICES (Sunnybank)

Suite 16–18 McCullough Centre
259 McCullough Street, Sunnybank QLD 4109

Bookings: (07) 3344 1422 or (07) 3344 1844

Fax: (07) 3344 2739

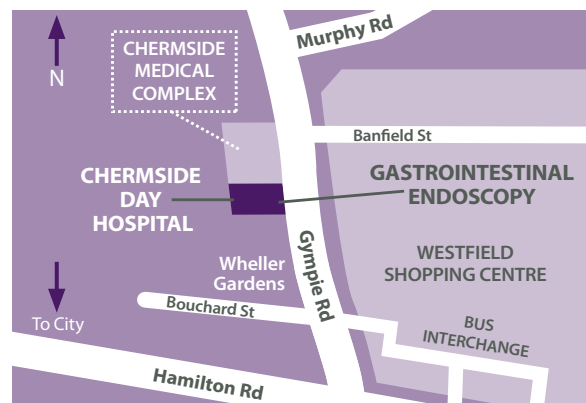
Parking

Chermside Day Hospital

Onsite car parking is available immediately behind the Chermside Medical Complex and in the upper level of the underground car park. **Disability car parking is available behind the Medical Complex.**

Entry to Chermside Day Hospital

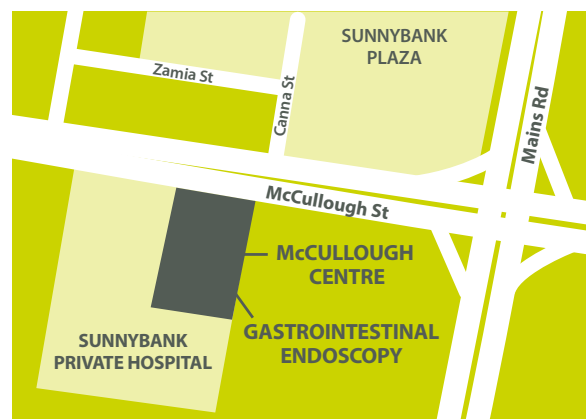
Entry to Chermside Day Hospital is via the car parks at the back of the Complex. Please take the lift to Level 1.



Parking

Brisbane Endoscopy Services

Onsite parking is available under the McCullough Centre building which is located on the same campus as the Sunnybank Private Hospital. **Disability car parking is available at the entrance to the McCullough Centre building.** To access Brisbane Endoscopy Services from the car park under the building, please enter via the stairs or take the lift to Level 1.



Accredited by the
Australian Council on
Healthcare Standards
until (March 2010)



International Standards
Certifications
Lic No: QAC/R61/0897

Clerical pre-admission

Financial consent

As a gastroenterology patient about to undergo a procedure at a private day hospital, you will receive two (2) fee estimates.

One fee estimate will be a 'Facility or Hospital Fee' from where you are to have your procedure (i.e. Chermiside Day Hospital or Brisbane Endoscopy Services at Sunnybank). This fee is an estimate of expenses for your day stay at the facility. This can be determined by your health insurance fund (if you have one) or quoted to you if you are self funded/pensioner/HCC holder etc.

Our clerical staff will provide you with an estimate of fees if there are any out of pocket expenses payable to our facility (e.g. an excess).

The second fee estimate will be the Doctors' fee. This fee will be either given to you by your Gastroenterologist or by the gastroenterology staff at Chermiside Day Hospital or Brisbane Endoscopy Services at Sunnybank.

Nursing pre-admission

Colonoscopy patients

When you ring our booking staff to make an appointment for your colonoscopy, you may be asked to attend one of our facilities for a 'prep kit appointment'.

What to bring if attending one of our facilities for a **Prep kit appointment:**

- Referral letter (*if applicable*)
- Medicare card
- Health fund number/details (*if applicable*)
- Pensioner/health care card (*if applicable*)
- Pages 3–6 of this booklet (*completed*)
- Method for settling your account (*EFTPOS, cash, credit card*).

Prep kit appointment

Our colonoscopy patients are interviewed by specifically trained Gastroenterology nurses who will assess your suitability and fitness for both the procedure and the preparation. Your medical history is discussed in detail. You will receive detailed written information about the preparation and procedure including risks. You will be advised when to commence your low residue diet and when to commence your colon prep solution which completely flushes out the colon.

This appointment takes approximately 20 minutes.

Day of Colonoscopy procedure

- You will be advised by your pre-admission nurse or your Gastroenterologist when to abstain from food and fluid prior to your colonoscopy. Please adhere to these instructions. Failure to do so may result in your procedure being cancelled
- Take your essential medications with minimal water unless otherwise instructed by your Doctor/pre-admission nurse
- Bring any relevant xrays and reports
- Bring something to read
- Bring method for settling your account (*EFTPOS, cash, credit card*)
- You will be at our facility for approximately 3–4 hours.

Upper Endoscopy patients

If you are asked to ring our booking staff to make an upper endoscopy appointment you will be advised of your appointment time and date for your procedure.

Day of Upper Endoscopy procedure

Fasting instructions:

- **No food for 8 hours prior to the procedure**
- **No fluids for 4 hours prior to your procedure**

Take your essential medications with minimal water unless otherwise instructed.

What to bring on the day of your procedure:

- Referral letter (*if applicable*)
- Medicare card
- Health fund number/details (*if applicable*)
- Pensioner/Health Care Card (*if applicable*)
- Pages 3–6 of this booklet completed (*if you have not already sent it in*)
- Any relevant xrays and reports
- Method for settling your account (*EFTPOS, cash, credit card*)
- Something to read
- You will be at our facility for approximately 3–4 hours.

After your procedure: Colonoscopy and Upper Endoscopy

YOU HAVE HAD AN INTRAVENOUS SEDATION

- For legal reasons you must not drive a vehicle, operate machinery or sign legal documentation for 12 hours following the procedure. Failure to do so carries the same implications as 'drink driving'. Please ensure you have made arrangements for a responsible adult to drive you home. Taxis are only acceptable if a responsible adult escorts you.
- **You must ensure you have a responsible adult to care for you for 12 hours post procedure and/or overnight depending upon your procedure time.**
- You must not care for dependant adults or children without responsible help.
- You will be unable to work on the day of your procedure.
- You must be very careful in simple household tasks in the 12 hours after receiving sedation. Your coordination may be impaired for some time and it is important, therefore not to use sharp knives, risk kitchen burns, etc.
- If you develop any pain, fever, vomiting or blood loss after the procedure, you should contact your referring Doctor immediately.

Rights and responsibilities

Patients rights

While in our care we respect your right to:

- Access safe, quality care free from discrimination
- Know the identity and professional status of attending staff
- Ask for and receive information on your health needs in terms you understand
- Be informed of the proposed procedure and associated risks
- Receive information necessary to give informed consent prior to the start of any procedure
- Be informed of the requirements for ongoing care following discharge
- Maintain dignity and respect while undergoing the procedure
- Know the estimated cost of the procedure
- Know that all aspects of care will remain confidential
- Make a complaint about any aspect of your care if you are not satisfied.

Patients responsibilities

While in our care you have the responsibility to:

- Work as a partner with the health care team
- Treat all staff and other patients with respect and consideration
- Provide accurate and complete information about your medical history, symptoms, medications and other matters relating to your health
- Indicate if you do not understand your proposed procedure and expected outcome
- Arrange suitable transport home and care after your procedure
- Follow the treatment plan recommended and notify the Doctor of any changes after discharge
- Meet the financial obligations in respect to the treatment provided
- Keep your appointment.

Affix patient label here

PATIENT TO COMPLETE and RETURN

Please FAX or RETURN in the self-addressed envelope to the Day Hospital Facility where you will have your procedure.

Admission details

Office/practice staff to complete

Admission date: ____ / ____ / ____ Admission time: _____ Proceduralist Doctor: _____

Procedure: _____

Patient to complete pages 3-6

Referring Doctor: _____ Address: _____

Have you previously been admitted to Chermide Day Hospital OR Brisbane Endoscopy Services (Sunnybank)? Yes No

If YES, when? _____

Have you been admitted to another hospital in the past 7 days? Yes No

If YES, where/when? _____

Patient details

Title: _____ Surname: _____ Given names: _____

Address: _____ Postcode: _____

Telephone: Home: _____ Work: _____ Mobile: _____

Date of birth: ____ / ____ / ____ Sex: Male Female

Health fund details

Medicare No. _____ Ref No. _____ Expiry date: ____ / ____ / ____

DVA No. _____ White card Gold card Expiry date: ____ / ____ / ____

Pension/Health Care Card No. _____ Expiry date: ____ / ____ / ____

Private Health fund: _____ Membership No. _____

Contributor's name: _____ Joined less than 12 months ago? Yes No

Person for notification

Next of kin: _____ Relationship: _____

Address: _____ Postcode: _____

Telephone: Home: _____ Work: _____ Mobile: _____

Emergency contact name: _____ Telephone: _____

Office use only

Prep kit paid? Yes No N/A

Health fund details confirmed? Yes No

Excess applicable? Yes No

Amount: \$ _____

Item Numbers: _____ Staff signature: _____ Date: _____

Remove top page and provide to Patient

Affix patient label here

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Queensland Health information

We are required to request that you answer the following six (6) questions for Queensland Health requirements.

- 1. Country of birth: _____
- 2. Indigenous origin: Australian Aboriginal Torres Strait Islander Australian South Sea Islander
- 3. Marital status: Never married Divorced Married Separated De facto Widowed
- 4. Occupation (if retired, please indicate previous occupation): _____
- 5. Are you an overseas visitor to Australia? Yes No
- 6. Funding source: Health fund Self-funded Medicare Medicare + self-funded

Financial consent

I agree, that in the event my health fund does not pay for all or part of my hospital and procedural fee, I agree to cover costs associated with my surgery at the facility where I will have my procedure.

Person responsible for account signature

Print name

Date

Relationship to patient (if not the patient): _____

Address: _____ Postcode: _____

Telephone: Home: _____ Work: _____ Mobile: _____

Consent for the collection and use of personal information

In providing you with the best possible health care we need to collect and use personal information. We must also comply with laws that require us to collect or disclose personal information about you. Other uses and disclosures of personal information are set out below. If you do not want us to use your personal information in one of these ways please tick the NO box next to that item.

Uses of personal information

- 1. To train and educate professional staff. Yes No
- 2. To assist in the development of service delivery and planning. Yes No
- 3. To inform next of kin identified in my admission form of the outcome of treatment. Yes No
- 4. To obtain consent to necessary treatment when I am not able to provide such consent. Yes No

Disclosures of personal information

- 5. To other medical practitioners, hospital or health service providers to assist in any current or future treatments that relate to the condition you are currently being treated for. Yes No
- 6. To enable this Day Hospital facility to provide access to information to your health fund if requested by the health fund to do so. Yes No

You are entitled to obtain access to the personal information we hold about you. If you request access to a visiting medical practitioner's notes please advise the facility in writing.

I have read and understand this form and, except where indicated, I consent to the collection, use and disclosure of my personal information for the purposes set out in it.

Patient's signature

Print name

Date

Affix patient label here

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Patient medical history

Planned procedure: _____ **List any allergies:** _____

Have you had any of the following conditions?

- | | | | |
|--|---|--|---|
| <input type="radio"/> Heart disease/heart attack | <input type="radio"/> Lung disease | <input type="radio"/> Bleeding disorder | <input type="radio"/> Glaucoma |
| <input type="radio"/> Heart murmur | <input type="radio"/> Asthma/Bronchitis | <input type="radio"/> Stroke/TIAs | <input type="radio"/> Blood clots |
| <input type="radio"/> Heart valve replacement | <input type="radio"/> Persistent cough | <input type="radio"/> Epilepsy/fits/faints | <input type="radio"/> Kidney problems |
| <input type="radio"/> Pacemaker/Defibrillator | <input type="radio"/> Shortness of breath | <input type="radio"/> Arthritis | <input type="radio"/> History of bowel/stomach cancer |
| <input type="radio"/> Chest pain/Angina | <input type="radio"/> Tuberculosis | <input type="radio"/> Hepatitis/jaundice | |
| <input type="radio"/> High blood pressure | <input type="radio"/> Sleep apnoea | <input type="radio"/> AIDS/HIV | |

Other illnesses/comments/details of above: _____

Are you diabetic? Yes No

If YES: diet-controlled tablet-controlled insulin-controlled

Please list all diabetic medications and doses: _____

Surgical history (please list previous operations and when): _____

Have you or anyone in your immediate family ever had a reaction to an anaesthetic? Yes No

If YES, please give details: _____

List regular medications including herbal or natural therapies (e.g. fish oil, ginkgo): _____

Do you normally take anti-coagulants or blood thinning medication? (e.g. Aspirin, Warfarin, Plavix) Yes No

Please name: _____

If YES, why do you take blood thinning medication? _____

Have you been taking any form of steroids? (e.g. cortisone, prednisone) Yes No Please name: _____

Dietary requirements: _____ Height: _____ Weight: _____ BMI: _____

Do you smoke? Yes No If YES, how many per day: _____ Have you ever smoked? Yes No

Do you drink alcohol? Yes No If YES, how many per week: _____

Do you have any visual, hearing or mobility impairment? Yes No

If YES, please give details: _____

Are there any comments you would like to make privately to your Doctor regarding your health? Yes No

Affix patient label here

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Creutzfeldt Jakob Disease

Creutzfeldt Jakob Disease (CJD) – similar to ‘Mad Cow Disease’ – is a rapid, dementing illness that is fatal. It is caused by an infectious protein or prion which is resistant to routine sterilisation and disinfection procedures. For this reason, we need to check for any CJD risk factors.

Have you had any of the following:

- 1. A family history of two (2) or more relatives with CJD or other unspecified progressive neurological disorder? Yes No
- 2. Received human pituitary hormones (growth hormones, gonadotrophins) prior to 1985? Yes No
- 3. Suffered from a recent progressive dementia, the cause of which has not been diagnosed? Yes No
- 4. Had a dura mater graft between 1972–1989? Yes No

Discharge arrangements

Responsible adult: _____
Name of person who will be collecting you after your procedure

Relationship to patient: _____

Telephone: Home: _____ Work: _____ Mobile: _____

I have been advised that I need to be discharged from this Day Hospital Facility into the care of a responsible adult who will care for me for at least 12 hours post procedure.

Please note: If you do not have a responsible adult to drive you home and care for you for at least 12 hours post procedure, your procedure may be cancelled.

I have read and understand this information and my responsibilities. The information I have provided on this and previous pages is true and correct.

Patient's signature

Print name

Date

Bowel history

To be completed by Colonoscopy patients only

Bowel habit: Normal Constipated Diarrhoea

Please indicate consistency/frequency: _____

If constipated, do you take regular laxatives? Yes No If YES, please list: _____

Abdominal pain/tenderness? Yes No Describe: _____

Have your bowel habits changed recently? Yes No If YES, how? _____

Have you passed blood or mucus recently? Yes No If YES, when? _____

Nurse to complete

Colon prep given: 3 litres Glycoprep + Ray kit 2 x Picoprep + 1 litre Glycoprep 3 x Picoprep

Extra prep given: _____

Patient's discharge arrangements discussed

Informed consent booklet given to patient

Polypectomy explained

Nurse's signature/Designation: _____ Date: _____