

19/201 Wellington Pde South, East Melbourne 3002

Telephone: (03) 9654 8033 Fax: (03) 9650 9998

Email: admin@jolimont.com.au

Please note: Entrance is off Jolimont Road

Date of Admission: _____

Previous Patient: Yes No

Procedure: Gastroscopy

Colonoscopy

Instructions for Patient:

- Please complete pages 1&2, and return to Jolimont Endoscopy at least 2 days prior to admission
- Contact Jolimont Endoscopy the day prior to your admission to confirm your appointment on 9654 8033
- Bring your Medicare, Health Care and Health Fund details on the day of procedure
- Do not bring valuables with you
- Wear comfortable clothing (If you are having a colonoscopy, please bring a dressing gown)
- Hospital accounts are to be settled on the day of procedure
- All doctors try to keep to time but sometimes there are unexpected delays due to unavoidable circumstances

SURNAME

TITLE

GIVEN NAME

MEDICARE NUMBER

EXPIRY DATE

OCCUPATION

 /

ADDRESS

State

Postcode

PERSONAL DETAILS

SEX

DATE OF BIRTH

COUNTRY OF BIRTH

M F

 / /

MARITAL STATUS

Married / De facto	<input type="checkbox"/>
Never Married	<input type="checkbox"/>
Widowed	<input type="checkbox"/>
Divorced	<input type="checkbox"/>
Separated	<input type="checkbox"/>
Unknown	<input type="checkbox"/>

VIC NSW SA QLD WA NT ACT TAS

Are you of Aboriginal or Torres Straight Island decent?

Phone Home

Phone Work

Mobile

Email

ALLERGIES

Yes No

Specify: _____

REFERRING GP

Address

Phone Number

HEALTH FUND DETAILS:

Fund Name / Vet Affairs / Workcover

Membership Number

Table / Level

PENSION:

Type

Number

PERSON RESPONSIBLE FOR ACCOUNT:

Patient

Other

please specify

CONSENT / REQUEST FOR PROCEDURE

I agree to be personally responsible for payment of all hospital treatment irrespective of any claim I may have against any health funds or third party. The answers that I have given to all questions are true to the best of my knowledge and I have not withheld any information. The nature of the procedure has been fully explained and I give permission for this to be carried out and the appropriate sedation anaesthetic to be administered. I understand that should I require admission to another hospital for further care I will be responsible for the costs involved. Following the procedure I will have a responsible adult take me home. I realise that impairment of full mental alertness may persist for the rest of the day. **I will not drive a car, operate machinery, drink alcohol or sign any legal documents on the same day after the procedure.**

I do voluntarily request the be performed.

SIGNATURE
If under 18 Parent or Guardian to sign

WITNESS
witness to signature only

DATE

PROCEDURALIST'S SIGNATURE

DATE

Who will be taking you home? Name Contact No.
or

I will be going home by taxi. Signature

PERSON TO CONTACT IN CASE OF EMERGENCY

Name

Phone

Relationship

GASTROSCOPY: Nothing to eat or drink 6 hours prior to procedure

COLONOSCOPY: Please refer to the detailed instruction sheet inside the bowel prep kit

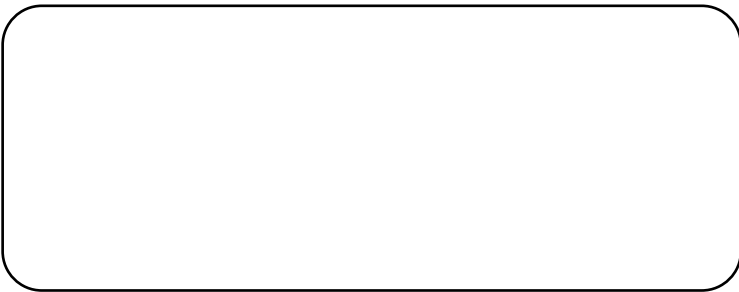
What time did you last eat? _____

What time did you last drink? _____

Bowel Preparation Completed? Y N

Please phone 9654 8033 as soon as possible to facilitate hospital registration and confirm your booking
Allow 2 hours for this procedure

If you have any questions at any stage do not hesitate to ask



Please tick Yes or No as applicable

	Yes	No
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker/Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Persistent Cough	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Tendency	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Fits or Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Migraine	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Ankle/Leg Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>
Physical Handicap	<input type="checkbox"/>	<input type="checkbox"/>
Contact Lenses	<input type="checkbox"/>	<input type="checkbox"/>
Glass Eye	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Limb	<input type="checkbox"/>	<input type="checkbox"/>
Dentures	<input type="checkbox"/>	<input type="checkbox"/>
Crowns	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

Admitting Nurse

Sign: _____

Date: ____ / ____ / ____

Time: _____

Please tick Yes or No as applicable

Do you drink coffee? (if YES, quantity per day _____) Yes No

Do you smoke? (If YES, quantity per day _____) Yes No

Do you drink alcohol? Yes No

Have you ever had any serious illness or disease? Yes No

(If YES, give details _____

Have you had previous surgery? If so, specify Yes No

Does a general anaesthetic cause any adverse reactions? Yes No

(If YES, give details _____

Are you currently taking any medicines or drugs? Yes No

(If YES, please list _____

Do you have any reason to believe that you may have been exposed to a virus which causes HIV(Aids) Yes No

CJD(Creutzfeldt - Jakob) Yes No

Have you had a dura mater or corneal graft? Yes No

Have you received human growth hormone? Yes No

