PATIENT IDENTIFICATION LABEL

Staff to tick & initial to indicate Clinical Handover at Point of Care	From: Reception	To: Admission Nurse
Patient ID & Procedure Match		
Alerts		
Medicare status		
Special requirements-including language		
Initial to indicate Clinical Handover at this Point of Care		

PATIENT ADMISSION DETAILS

Admitting Doctor/Surgeon **(肠胃镜医生)**:

General Practitioner (Name and Address) **家庭医生 (姓名 & 地址)**：

Date of Admission **(肠胃镜日期)**::

Operation/Procedure **(手术名称)**::

Have you been hospitalized anywhere in the last seven days? **(七天之内去过任何一家医院吗?)**
Yes□ No□ If yes, where? **(如果有, 在哪)?**

PATIENT DETAILS (病人资料) – Please print as your name appears on Medicare Card *请填写医疗卡上的姓名*

Title: Mr/Mrs/Ms/Miss	Surname **(姓氏):**	Previous Surname **(之前的姓氏):**

Given Name **(名字):**

Address **(地址):**	Postcode:

Phone (H) **(家里电话):**	(M) **(手机号码):**	(B) **(工作电话):**
Sex: Male□ Female□ **(男) (女)**	Date of Birth **(生日)**：	Marital Status **(结婚/ 单身):**

Country of Birth (if Australia, which state) **(出生国家)?**	Are you an Australian Resident? Yes□ No□ **是澳大利亚国籍吗?** Are you of Aboriginal/Torres Strait Island Descent? Yes□ No□ **是原住民吗？**

Medicare number: **(医疗卡号码):**	Reference No:	Expiry Date:	Veteran's Affairs No.

Pension No. **老人卡号码** Health Care Card **健康卡**	Expiry Date: 过期日期

Private Health Fund **(保险公司名称):**	Membership Number **会员号码:**

Next of KIN (Person to contact in case of Emergency) (紧急联络亲属)

Name **(姓氏):**	Relationship **(与病人的关系):**

Contact Number **(联络电话):**

ESCORT CONTACT DETAILS (Who will be taking you home?) (接送人联络资料)

Name **(姓氏):**	Relationship **(与病人的关系):**

Contact Number **(联络电话):**

Charter of Rights: I have read and understand my rights as per Rights & Responsibilities Information provided by SEC
Patient Signature (病人签名):

PRE-ANAESTHETIC ASSESSMENT

Patient to complete. Admission Nurse to review with patient at time of pre-operative assessment, then handover to Doctors prior to consultation.

PATIENT ID LABEL

1. Medical History 病史

Have you ever had any of the following complaints?
If yes to any of the above please give details:

_____

_____

	Yes	No
High Blood Pressure (高血压)		
Heart Attack (心脏病)		
Blood clotting problems (血液凝固问题)		
Angina (心绞痛)		
Stroke (中风)		
Rheumatic Fever (风湿热)		
Blood clot in legs or lungs (脚或肺血液凝固)		
Kidney Disease (肾脏疾病)		
Diabetes (糖尿病) Type 1 or Type 2		
Anaemia (贫血)		
Pneumonia or Tuberculosis (肺炎/肺结核)		
Hepatitis or Jaundice (黄疸/肝炎)		
Eczema (皮肤敏感)		
Hay Fever (花粉过敏)		
Nervous Breakdown (神经衰弱)		
Epilepsy or fitting (癫痫)		
Prosthetic Joints (关节置换)		
Heart Valve Replacement (心脏手术)		
Recent Cold (感冒)		
Other serious illness (其他严重疾病)		

1. Allergies (过敏)

Do you have any allergies? Yes No
(你有对什么过敏吗?)
If Yes, 若有, 请说明 _____

2. Medications (药物)

Please list your current Medications
(请例下您服用的药物)

_____
_____
_____
_____
_____

3. Surgical History (手术历史)

Have you had any previous operations? Yes No
您之前动过手术吗?
Details: (若有, 请填写)

Operation 手术	Year 年份

4. Anaesthetic History (麻醉历史)

Have you or a family member had an anaesthetic complication?
(您或您的家人曾有过麻醉的问题吗)? Yes No
Details: (如果有, 请说明)_____

_____
_____

	Yes	No
Do you smoke? (抽烟吗)? How Many? (一天抽多少?) Last smoke? (最后一次抽烟是几时?)		
Do you drink Alcohol? (喝酒吗)? How much per day? (一周喝多少?)		
Have you had a recent hospital stay? (最近有住院吗?)		
Have you been in to hospital overseas in the last 12 months?		
Have you had any falls in the past 3 months?		
Have you had any significant weight loss in the last 3 months?		
Have you had a temperature in last week? (上星期有发烧吗?)		
Females, Are you Pregnant? (女性, 你有怀孕吗?) If Yes, EDC (若有, 估计的分娩日期)		
Do you require any assistance with mobility or use any aids such as walking stick, frame? (您有行动不便吗? 例如, 拐杖?)		
Do you have any issues with skin integrity such as ulcers, skin tears, lesions or wounds? (你有任何皮肤破裂问题吗?)		
Do you require assistance to communicate? (沟通上需要协助吗?) Hearing or vision deficit, cognitive impairment? (听力或视力不足，认知障碍)		
Do you require an interpreter? (你需要翻译吗?) If so what language? (若需, 什么语言?)		

OFFICE USE ONLY:

Height:_____ Weight: _____ BMI: _____

Prep instructions followed correctly: Yes No

Do you take blood thinner medication? Yes No

If yes, medication: _____Last taken: _____
Time of last food: _____ ***Time of last drink:*** _____
Suitable escort arrangements: _____
Nursing Notes:

_____

Staff to tick & initial to indicate Clinical Handover at Point of Care	From: Nurse	To: Endo	To: Anaes
Patient ID & Procedure Match			
Alerts/Allergies			
Relevant Medical history			
Fasted and Prep completed correctly			
Special requirements-including language, skin issues, mobility			
Suitable escort arrangements			
Initial to indicate Clinical Handover at this Point of Care			

Nurse Sign:_____
Print:_____