Dr Sunil P Kaushik MBBS (Hons, UNSW), FAMS, FRACP
Gastroenterologist
West Coast Endoscopy Centre
1/32 Pimlico Place Joondalup WA 6027
Tel: (08) 9301 4437 Fax: (08) 9301 4438

ADMISSION FORM - Form 1

Please bring your completed forms with you on the day of your procedure. This will assist in preventing delays on admission.
Our address is : 1/32 Pimlico Place, Joondalup, 6027.
Email address: bookings@wcendo.com.au Fax: 9301 4438. Website : www.westcoastendoscopy.com.au
Doctor's Name: Dr Sunil P Kaushik

Patient Details

Surname: _____
Given Names: _____
Address: _____
Telephone Numbers: Home: _____ Work: _____ Mobile: _____
Age: _____ DOB: _____
Australian Aboriginal: _____ Country of Birth: _____
Occupation:_____ Marital Status: _____

Next of Kin Details
Name: _____
Address: _____
Relationship to Patient: _____ Telephone Numbers: _____
Is this the person collecting you: yes / no
If no, please state name and contact number of person collecting you:
_____

Health Insurance Information

Name of Insurance Fund: _____
Fund Membership Number: _____
Medicare Number: _____

Have you been hospitalised or a hospital employee interstate or overseas in the last 12 months? Yes / No

Patient Signature: _____

West Coast Endoscopy Centre
Hospital Pre Admission Forms
NURSING QUESTIONNAIRE - FORM 2

Previous operations, if any?

_____

_____

Please list current medication including non prescription:

_____

_____

Have you ever had any of the following?

(Please circle Yes or No in response to the question. If yes please provide further explanation.
If completing the form electronically, please **bold** the correct response.)

Problem/Condition	**Yes**	**No**	**Explanation**
Do you have any allergies?	Yes	No	_____
Special dietary requirements e.g. vegetarian/gluten free			
Were you affected by previous anaesthetics?	Yes	No	_____
Are you taking any blood thinning agents?	Yes	No	_____
Cold/Flu in past week or infections in the past month?	Yes	No	_____
Lung or breathing problems?	Yes	No	_____
If lung disease do you use home oxygen?	Yes	No	_____
Do you use an inhaler?	Yes	No	_____
High Blood Pressure?	Yes	No	_____
Chest pain/Angina?	Yes	No	_____
Heart Conditions/or heart attack?	Yes	No	_____
Diabetes?	Yes	No	_____
Fits/Epilepsy?	Yes	No	_____
Stroke/ Blackouts/Fainting?	Yes	No	_____
Blood clots/bleeding/bruising?	Yes	No	_____
Liver problems/hepatitis B, C, HIV?	Yes	No	_____
Kidney problems?	Yes	No	_____
Back/neck problems?	Yes	No	_____
Are you being treated for any other illness?	Yes	No	_____
Smoke?	Yes	No	_____
Drink Alcohol?	Yes	No	_____
Hearing - Normal	Yes	No	_____
History of falls or mobility problems?	Yes	No	_____
Have you been in hospital outside WA in last 12 months?	Yes	No	_____

(If yes MRSA form needed)

Please enter your weight: _____kg **height: _____cm**

Patient Signature: _____ Date: _____

Nurse name: _____ Nurse Signature: _____ Date: _____

West Coast Endoscopy Centre - Hospital Pre Admission Forms
CONSENT - FORM 3

I _____, consent to Flexible Sigmoidoscopy being performed upon myself.

I have read the information sent to me regarding the procedure(s) and have been adequately informed to have the procedure(s). I am aware that for Colonoscopy there is a 1:1000 risk of perforation of the bowel and 1:200-400 chance of bleeding if a polyp is removed. Also for Endoscopy a small chance exists of damaging my teeth. I also consent to such further or alternative operative measures as may, in the operation of the Doctor, be found to be necessary during the course of the operation and to the administration of a local or other anaesthetic.

If I cannot have a blood product or blood transfusion I agree to release West Coast Endoscopy Centre and staff from all liability for respecting my wishes and direction. I am aware that it is my responsibility to inform staff at West Coast Endoscopy Centre of my wishes. **Please bring any relevant documentation.**

If any staff member is injured or exposed to me (or my child's) blood or any other body fluid, then I give my consent to blood being collected and tested for infectious agents, including hepatitis and HIV antibody.

If I have an advanced care or end of life directive, it is my responsibility to inform staff at West Coast Endoscopy Centre. **Please ensure you bring this document with you.** (This is a legal document advising staff of the medical care you wish to receive relevant to the end your life).

I am responsible for any payment not covered by Medicare or my Health Fund and I confirm that checking my health fund entitlement is my responsibility.

If my procedure is an "Open Access Booking" i.e. without having a consultation, I acknowledge that I am satisfied with this type of booking and the written explanation I have received.

I am aware of my rights and responsibilities. (See attached page)

I agree that my medical information will be used in accordance with the privacy act 1988. (Copy of privacy policy available upon request)

All personal information supplied by you is confidential and only that which is required to provide your medical service is collected. The collection and handling of this information is within the guidelines of the Privacy Act. If you wish to view our privacy and/or complaints/compliments information it is available at reception.

I accept that because the use of mobile phones are not allowed, my mobile phone will be locked away after I have been admitted and returned to me before I am discharged. I also accept that whilst all due care will be taken of mobile phones and valuables, WCEC takes no responsibility for loss/theft or damage if you have brought these with you.

I have read and understand the Discharge Plan instructions. If I disregard advice on driving and/or having a responsible adult with me on the day and night of the procedure, I accept full responsibility for failing to follow this advice.

WCEC is an accredited healthcare facility and as such comply with all relevant Australian standards including the NSQHS, DOH and ISO. However, there is always a small risk which is unquantifiable of cross infection of infectious organisms such as MRSA, CRE or VRE as may occur in any healthcare facility.

Dated this _____ Day of _____ 2017 Sign Here _____

Doctor's Confirmation:

I confirm that the nature, purpose and risks of this procedure/treatment have been explained to the person who signed the above consent form.

Signed: _____ Date: _____

Name: **Dr Sunil P Kaushik**

WEST COAST ENDOSCOPY CENTRE
FINANCIAL INFORMATION AND CONSENT

Please contact your health fund, fill in the information below and **bring all the completed admission forms with you on the day of your procedure. It is your responsibility to check with your health fund if you are covered** for the procedure, as it is very important that you as the patient know whether certain conditions exist, as this could result in an out of pocket expense for you.

When contacting your health fund, firstly ask who you are speaking with:

Name: Date: Time:

Then ask these questions about conditions that may apply to you and could result in out of pocket expenses:

1. Eligibility – *"Am I covered to go to West Coast Endoscopy Centre for an Endoscopy/Colonoscopy or both?"* Endoscopy item number: 30473 Colonoscopy item number: 32090 Colonoscopy and Polypectomy item number: 32093 (please circle): Yes No

2. Excess on policy – *"Do I have an excess? What is the amount?"* Yes No Amount $

3. Co-payment – *"Are there any Co-Payments?"* Yes No Amount $

4. Pre-existing ailment/ waiting period rule – *"Is my condition Pre Existing?"* Have I served my waiting period? (If you have not served a 12 month waiting period in some circumstances you may not be covered and will be asked to have your doctor fills in a "pre-existing ailment form".

Waiting periods served; Yes No if **No** please contact West Coast Endoscopy Centre.

5. Other fees may be incurred from the Anaesthetist and Pathology and it is your responsibility to contact them regarding any payments. (Western Diagnostics pathology : 9317 0999)

6. I am aware that West Coast Endoscopy Centre may provide information about me to a Credit Reporting Agency, but only limited information as allowed under Section 18E(1) of the Privacy Act 1988 (Commonwealth).

7. The account stay your responsibility if your Healthfund does not pay it. If we have to employ a debt collector to collect any outstanding money, 20% of your outstanding account will be added to your account to cover that cost.

8. Dr Kaushik provider number : 203165MX / West Coast Endoscopy Centre provicer number : 075640L

Please note : We do have contracts with all major funds and only charge those fees. Unfortunately we don't have a contract with HCF which means you might be out of pocket for most of the account or even the whole account .

Please sign below to acknowledge that you have contacted your health fund and have understood the financial consent process.

I accept full financial responsibility if I do not follow these instructions.

Patient Signature: _____ Date:_____

WEST COAST ENDOSCOPY CENTRE
PATIENT RIGHTS

- Be treated with respect for your dignity, beliefs and right to privacy
- Expect high standards of care consistent with your needs
- An explanation of your procedure and its associated ricks before giving consent
- Be included in decisions and choices about your care
- The services of an interpreter
- Decline treatment after accepting responsibility for the consequences
- Have advice on how to make a complaint/compliment
- Be aware of all costs involved in your treatment as far as possible
- Advice on care after discharge
- Access to your medical record if required

As a patient of WCEC you have the responsibility to;

- Co-operate with staff during your treatment in order to aid your recovery
- Be open and frank about your medical history so as to ensure you receive the best care
- Let staff know about any special needs you may have including dietary, language, cultural or religious needs
- Accept the consequences of your own decisions on health matters
- Direct any criticisms of the facility to a staff member so that appropriate steps can be taken to remedy any problem (refer to complaint brochure)
- Respect the dignity of staff members, other patients and visitors and their right to a safe environment. Aggressive behaviour may result in the withdrawal of care.
- Keep scheduled appointments and let staff know if you are unable to do so.
- Remain responsible for the security of your own property
- Be considerate in your arrangements with the Centre
- Have respect for our relevant policies