the glen endoscopy centre

Admission Assessment Form

Name (名字): ________________________________________

Appointment (预约日):

Date 预约日期: __________________ Time 时间: ____________

OFFICE USE: Confirm correct patient? Yes/No    Seen By: ______________________________ Time: _______________

Time patient last ate: _____________________ last drank: ______________________ Bowel Prep: Complete/Incomplete

**Patient Pre-Admission Health Assessment – completed by the patient 患者住院前健康评估 - 由病人完成**

| Who is taking you home? Relationship to you:<br>谁带你回家？ 与您的关系: | **Walking, unescorted in taxi & public transport not allowed**<br>**不允许独自步行，坐出租车或公共交通车** |
|---|---|

I have read and understood the preparation instructions, risks and safety of procedures, and had an opportunity to ask any questions I may have.
我已阅读并理解检查前准备说明，检查的风险和安全性，并有机会提出任何问题。

Name: Sign: Date:

| Procedure you are having: Age:<br>今天您来做什么检查： Colonoscopy 肠镜 Gastroscopy 胃镜 年龄： | **仅限办公室使用:**<br>**OFFICE USE ONLY:** |
|---|---|
| **Why are you having this test? 您为什么需要此项检查？ 请圈**<br>Swallowing difficulty 吞咽困难 / Nausea 恶心 / Vomiting 呕吐 / Bleeding 出血<br>Appetite loss 食欲不振 / Heartburn 烧心 / Discomfort 不适 / Anaemia 贫血<br>Bowel habit change 排便习惯改变 / History of polyps 息肉病史 / Pain 疼痛<br>Bloating 腹胀 / Weight loss 体重减轻 / Iron deficiency 缺铁<br>Family cancer 肿瘤家族史 / FOBT + 血便检查阳性<br>Other reasons 其他原因： ____________________________________________________ | Clinical indications |
| Previous surgery and year of surgery: 您之前是否有做过手术，什么手术及手术年份: | Past Surgical history: |
| Significant medical problems: 您有哪些严重的病史? | Past Medical history: |
| **Relevant family history 相关的家族病史:**<br>First degree relative with cancers?<br>直系亲属患有癌症? Specify说明: ____________________________<br>First degree relative with early heart disease (under 65yo)?<br>直系亲属患有早期心脏疾病（65 岁以下）? Specify说明: _________________ | Relevant family history: |

Name (名字) : ______________________________

**MEDICATIONS YOU TAKE:** List all prescribed, over-the-counter and complimentary medications you take. Provide a list of your medications if you have it with you.

**您服用药物:** 列出所有处方，非处方药物和补充药物，如果您有清单，请提供您的药物清单

| **Name of medication** 药名 | **No. of tablets** 片数 | **Frequency per day** 每天服用次数 | **Why are you taking this medicine?** 服用药物的原因 | 仅限办公室使用 **OFFICE USE ONLY:** Medication history: |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |

Has there been any change to your medicines in last 3 months? If yes, what has changed?

在过去 3 个月，您是否更换过任何药品？如果有，更换了哪些药品？ ____________________

**Allergies** – Do you have allergies to any of these**? 过敏 –您是否对以下物品过敏? 请圈**

| Eggs 鸡蛋 | Soya 大豆 | Any Medications 任何药物 | Anaesthetic agents 麻醉剂 | 仅限办公室使用 **OFFICE USE ONLY:** Allergy history |
|---|---|---|---|---|
| Latex 乳胶 | Hay fever 花粉症 | Chlorhexidine Disinfectant 洗必泰消毒剂 | Tapes, cream 皮肤胶带, 乳霜 | |

**If allergy, name of medication & describe the reaction you get 如果过敏，请写出您服用的药物及您的过敏反应:**

**If significant allergy, staff change to red ID band 如果严重过敏，工作人员将更换为红色 ID 腕带**

**Intake 摄入量**

| | | | |
|---|---|---|---|
| Smoking 吸烟 | If yes, how much? 如果是，多少？ ________ / per day / 天 | Recreational drugs 消遣性毒品 | If yes, specify: 如果是，请指定： ________ |
| Alcohol 饮酒 | If yes, how much? 如果是，多少？ ________ | 仅限办公室使用 **OFFICE USE ONLY:** Relevant consumption history: | |

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**To be completed by Patient** 请病人勾选是或否

| **CARDIOVASCULAR – Heart Issues**<br>**心血管 - 心脏问题** | Yes<br>是 | No<br>否 | **RESPIRATORY – Lungs or Breathing**<br>**呼吸系统 - 肺或呼吸** | Yes<br>是 | No<br>否 |
|---|---|---|---|---|---|
| Shortness of breath at rest/lying flat/mild exertion<br>休息 / 平躺 / 轻微用力事时呼吸短促 | | | Hay fever, sinus problems<br>花粉症，鼻窦问题 | | |
| High blood pressure 高血压 | | | Asthma 哮喘 | | |
| Chest tightness, chest pains, angina, heart attack, heart disease<br>胸闷，胸痛，心绞痛，心脏病发作，心脏疾病 | | | Chronic bronchitis, emphysema, chronic airway disease, bronchiectasis<br>慢性支气管炎，肺气肿，支气管扩张，慢性呼吸道疾病 | | |
| Rheumatic fever, heart murmur<br>风湿热，心脏杂音 | | | Moderate-heavy snoring<br>中度，重打鼾 | | |
| Irregular pulse, palpitations, arrhythmia<br>脉搏不规则，心悸，心律不齐 | | | Obstructive sleep apnoea<br>阻塞性睡眠呼吸暂停 | | |
| Ankle swelling<br>踝关节肿胀 | | | CPAP, BiPAP at night, Home oxygen<br>CPAP，夜晚无创通气，家庭输氧 | | |
| Pacemaker, artificial heart valve, Implanted devices<br>心脏起搏器，人工心脏瓣膜，植入设备 | | | Gastrointestinal: Hiatus Hernia, Reflux, Gastric ulcers<br>胃肠道: 食管裂孔疝、食管反流、胃溃疡 | | |
| **METABOLIC/ENDOCRINE**<br>**代谢/内分泌** | | | **TEETH, SKIN, MUSCULOSKELETAL**<br>**牙齿，皮肤，肌肉骨骼** | | |
| Could you be pregnant now?<br>您现在有可能怀孕吗? | | | Any skin conditions, broken skin, wounds<br>任何皮肤状况，破损的皮肤，伤口 | | |
| Contraceptive pill, Breastfeeding,<br>避孕药，母乳喂养<br>**NB: oral contraceptive may not be effective during the bowel preparation (口服避孕药在肠道准备期间可能无效)** | | | Pressure areas, reddened skin due to friction/rubbing/pressure<br>受压部位，由于摩擦/揉搓/压力而造成的皮肤发红 | | |
| Diabetes? Diet/Medications/Insulin (pls circle)<br>糖尿病？饮食/医药/胰岛素（请圈） | | | Loose teeth, chipped teeth<br>牙齿松动，牙齿碎裂 | | |
| Liver conditions, fatty liver, jaundice, hepatitis, cirrhosis<br>肝脏疾病，脂肪肝，黄疸，肝炎，肝硬化 | | | Caps, crowns, veneers, dentures, bridge, other dental works<br>牙冠，贴面，假牙，桥梁，其他牙科治疗 | | |
| Kidney conditions, kidney impairment<br>肾的问题，肾损伤 | | | Neck trouble? A bit /Some /A lot<br>颈部问题? 一点儿 / 一些 / 很多 | | |
| Lap band surgery, gastric banding surgery?<br>是否有做过圈带手术，胃束带手术? | | | Jaw trouble? Eg. Pain, click, locking<br>下颚？ 例如。疼痛，锁定 | | |

Name (名字) : ________________________________

| NEUROLOGICAL, SEDATION 神经，镇静 | Yes 是 | No 否 |
|---|---|---|
| Fits, epilepsy, TIA, strokes, Parkinson's 癫痫，TIA，中风，帕金森病 | | |
| Memory issues, dementia 记忆障碍，痴呆症 | | |
| Intellectual disability 智力障碍 | | |
| Faints, funny turns, dizzy spells 晕倒，疯笑，头晕 | | |
| Past sedation or anaesthetic difficulties 以往的镇静剂或麻醉问题 | | |
| Post-anaesthetic confusion / delirium 麻醉后神智不清 / 精神错乱 | | |
| History of mental illness, e.g., depression, anxiety, psychosis 精神疾病的历史，例如抑郁，焦虑，精神病 | | |
| **MOBILITY, FITNESS & WELL-BEING 移动性，健身与健康** | | |
| Do you use a mobility aid? e.g., a walking stick 你使用助行器吗？ 例如，拐杖 | | |
| 体重 (Weight) __________ 公斤 (kg)<br>身高_(Height) __________ 厘米 (cm) | | |
| Have you had any falls in the last 12 months? 您在过去 12 个月中是否有过任何跌倒?<br>无 (0) 一次 (1) 两次 (2) 三次以上 (3) | | |

| BLEEDING/CLOTTING 出血/凝血 | Yes 是 | No 否 |
|---|---|---|
| Blood thinning medications? Anti-platelet medications? Bleeding tendency? 血液稀释药物？抗血小板药物？出血倾向？<br>**Any of: Clopidogrel / Plavix / Iscover / Apixaban / Dabigatran / Rivaroxaban, Prasugrel & Ticagrelor / Warfarin, Coumadin?** | | |
| Deep venous thrombosis DVT, Pulmonary embolism ie. Blood clots in legs or lungs 静脉血栓, 肺栓塞，腿部或肺部血液凝块 | | |
| Have you bought an *Advance Care Directive* with you? If yes please inform the Doctor 您是否已买一个"高级护理指示 "或"生前预嘱"？ | | |
| **INFECTIONS 感染** | | |
| Past 12 months, any admission (overnight or more) to any overseas healthcare facility) 过去 12 个月内，在任何国外医疗机构住院（一夜或以上） | | |
| Past 12 months, any CRE infections or contact with any patient with CRE. 过去 12 个月内, 您有过抗碳青霉烯类肠杆菌 (CRE) 感染或与任何 CRE 患者接触. | | |
| Are you currently being treated for any infections? Ever had TB/Tuberculosis? 您目前正在接受感染治疗? 曾经有肺结核? | | |
| Have you been overseas in the last month? 在过去一个月内，您有出国吗？ | | |
| In the last 10 days, have you had any respiratory infection (cold, sore throat, runny nose, sinusitis, cough, flu) or gastroenteritis (vomiting, diarrhoea)? 在过去 10 天内，您有过任何呼吸道感染（感冒，喉咙痛，流鼻涕，鼻窦炎，咳嗽，流感）或胃肠炎（呕吐，腹泻）？ | | |

**I acknowledge I must not drive/operate machinery/sign legally binding documents within 24 hours of my anaesthetic.**
**我认知在我进行麻醉之后的 24 小时内，我不能驾驶/操作机械/签署具有法律约束力的文件。**
**I acknowledge I must have a responsible adult stay with me on the day of my procedure and overnight.**
**我认知今天必须有成人能陪我一整天和一整晚。**
**Acknowledgment that the patient/representative has filled in this form: 确认您，病人/代表已填写此表：**

Patient name: Sign: Date today:

**Office use only** Pre-Admission completed by: Name: ______________________ Sign: __________________ Date: _____________

Pick up & Carer overnight
24 hrs rest after anaesthetic – no work/ drive/ exercise etc
Bowel prep instructions and risk informed consent

Notes/Actions:

Sign: __________________ Date: _____________

Approved for admission YES / NO PAC required YES /NO

# 病人登记表

您有权利享受到中心人员为您提供高品质，周到，安全及高效的 医疗服务。在中心登记的合格医师中作出选择为您诊疗。要求第二位医生的医学建议和判断。拒绝任何一个不直接参与您治疗的人员离开现场。询问医生或者医院人员您的治疗费。要求对您的诊疗进行详细的解释。拒绝进行诊疗。要求依照"隐私权法" 严格保密您的个人信息。要求员工尊重您的信仰，文化背景以及宗教习俗。对您在中心所接受的服务发表建议或投诉。
本中心希望病人和病人的家属及朋友能够以充分的礼貌和尊重对待中心人员，其他病人和病人的家属及朋友。

| **患者详细信息 Patient Details** | | |
|---|---|---|
| | 名字<br>Given Name: | 姓<br>Surname: |
| 地址<br>Address : | 市郊<br>Suburb: | 邮编<br>Postcode: |
| 电话号码<br>Phone No.: | 生日 (日日 / 月月 / 年年年年)<br>DOB: | 婚否<br>Marital Status: |
| 邮件<br>Email: | 出生国<br>Country of Birth: | |
| 原住民/或托雷斯海峡岛民 Are you [is the person] of Aboriginal or Torres Strait Islander origin?<br>No Yes, Aboriginal Yes, Torres Strait Islander Yes, both Aboriginal and Torres Strait Islander Decline to answer | | |
| 医保卡号码<br>Medicare No:<br>* please advise staff if your Medicare card is reciprocal as it will not cover for this procedure | 序号 Ref no: | 有效期 Expiry Date: |
| 私人医院保险公司名与卡号码<br>Private Hosp Insurance Fund &<br>Membership no.: | 救护车保险<br>Ambulance Cover 是 Yes 否 No<br>*在不可预见的情况下，如果病人需要救护车，请注意，这费用将由病人支付 | |

| **护送联系方式 (带你回家的人) Person taking you home** | | |
|---|---|---|
| 名字 Name: | 与您的关系 Relationship: | 电话 Contact No: |

| **紧急联系信息 Emergency Contact Details** | | |
|---|---|---|
| ☐ 如上所述 Same as above 是 Yes 否 No 如果不是，填写以下信息 , if not, please fill in below: | | |
| 名字 Name: | 与您的关系 Relationship: | 电话 Contact No: |

| **授权委托 (任命某人代表你做决定的法律文件) Power of Attorney** | | |
|---|---|---|
| 你有授权委托吗？Do you have a Power of Attorney? 是 Yes 否 No 如果有，填写以下信息 | | |
| 名字 Name: | 与您的关系 Relationship: | 电话 Contact No: |

**注意：** 按照隐私权法修正案（私营部门）2000， Glen 肠胃镜诊疗中心在次声明当您自愿成为本中心的病人时，我们需要收集您的信息，以使能够为您提供高品质，周到，安全及高效的医疗服务。由于我们是一家政府注册的日托医院， 所以我们询问您所获得的信息需要提交给政府部门。此外为了给您提供所需要的服务，我们收集的信息将被传递到其他医疗服务提供者，如病理学家。
我， ____________________________ , 在此同意 Glen 肠胃镜诊疗中心的管理人员向医学工作者，政府以及其他法定团体传递我的信息，以此来实现为我个人提供高品质，安全及高效的医疗服务，同时满足政府和其他法令，法规的规定。

签字 ______________________________________________________________ 日期 ________________