

# The Newland Street Specialist Centre

Incorporating:

**The Sydney Clinic for Gastrointestinal Diseases**

The Sydney Clinic for Ocular Diseases & Disorders

Level 10, 1 Newland Street  
Bondi Junction NSW 2022  
Telephone No. (02) 9369 3666  
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Email: [bookings@nssc.com.au](mailto:bookings@nssc.com.au)  
Website: [www.nssc.com.au](http://www.nssc.com.au)



## PRE-ADMISSION FORMS

Name: .....

Procedure: .....

Day: .....

Date: .....

Approx Time (to be advised): .....

Doctor: .....



Please take the time to read and complete the relevant documents carefully.

**Please notify the clinic if you are diabetic**

**Dr's referral needed on day of admission:**

Yes ☐ No ☐

**Scheduled admission time may change up to 24hrs prior provisional time only**

We are a Day Procedure Centre/Same Day hospital.  
Licensed by the NSW Health Department.  
Accredited with The Australian Council on Healthcare Standards.

Welcome to the Newland Street Specialist Centre

Incorporating:

- The Sydney Clinic for Gastrointestinal Diseases;
- The Sydney Clinic for Ocular Diseases & Disorders.

**Thank you for choosing us, we hope your stay will be comfortable and pleasant as possible.**

The clinic provides quality care in a warm, personalised setting.

**NON-English speaking persons.** If you require an interpreter, please contact 131 450 in advance of your admission and inform clinic staff. 2-3 weeks notice is required to organise an interpreter.

### **Pre-Admission Information**

Please bring to your admission

- Your complete paperwork
- **DOCTOR'S REFERRAL** if requested by our staff.
- A list of current medications.
- Medicare card.
- Health fund membership card.
- Veteran Affairs / Pension cards.
- Insurance details if subject to Work Cover or Third party claim.

### **Dietary Requirements**

If you have any special dietary requirements eg. Coeliac / Kosher bring a snack for after the procedure. **Please refer to the guidelines for bringing food into our clinic. Check website: [www.nssc.com.au](http://www.nssc.com.au)**

Allow 3 hours for your stay at the Clinic.

Ask our staff for an estimated departure time. We will ring your escort half an hour prior to your departure. Please provide a telephone/mobile number for your escort to be contacted.

The front doors of the building are locked automatically until 7am and after 6.30pm for security purposes.

If you have any questions about the procedure, completion of forms, cost or health insurance status, our staff will be happy to assist you.

A staff member will contact you prior to your admission to confirm your booking, likely costs and answer any questions you may have. **(Please be advised your scheduled admission time may change up to 24 hours prior).**

Should you decide to cancel your appointment, notify the Clinic as soon as possible. Failure to do so may incur a cancellation fee.

### **On The Day Of Admission**

(Unless your Doctor gives you special instructions)

- **FAST AS PER SPECIALIST PROCEDURE INSTRUCTIONS.** A stomach full of food or water could endanger your safety.
- **TAKE YOUR USUAL MEDICATION** as advised by the doctor, with a sip of water on the day of your admission.
- If a headache develops you can take Panadol as per the packets instructions.
- Diabetics, do not take your medication but bring it with you.
- Asthmatics, please bring your inhalers.
- Wear comfortable, loose warm clothing.
- Do not wear jewellery (wedding ring and watch are permitted)
- **If any change in your physical condition develops prior to your admission, that is, a cold or persistent cough or fever, ring our nursing staff for advice.**
- Arrive at the Clinic at the time allocated to you by the staff.
- If applicable, payment for the procedure / operation is required on admission.
- Advise us if you require a medical certificate for work.
- Every effort is made to run to schedule but unavoidable delays may occur and we will keep you informed of such.

### **Sedation and our Discharge Policy**

The administration of sedation affects your short-term memory. You may feel in control and not feel the effects of the sedation, but your judgement will be impaired.

**In accordance with NSW Health Department Directives + Anaesthetic guidelines.**

### **You must**

**Have an adult collect you from the Clinic on the 10th floor.**

**Follow all discharge instructions (verbal and written) given to you by staff, as per anaesthetic guidelines.**

We take our responsibility to you, your health and your safety very seriously.

**It may be necessary to cancel your procedure if you are unable to arrange for an adult to collect you from the Clinic on the day of your procedure.**

### **You must not** (until the following day).

Make any legally binding decisions

Drive a motor vehicle for the rest of the day

Go home by taxi (unless you are accompanied by an adult)

Drink alcohol for the rest of the day

Return to work after your procedure

If you have any unexpected problems please contact your doctor on the telephone number provided on your discharge instructions.

# The Sydney Clinic for Gastrointestinal Diseases

## PERSONAL DETAILS

TO BE COMPLETED IN FULL BY PATIENT

Title (Mr, Mrs, Ms, Miss, Dr, Prof, etc.)

(circle)

**SURNAME**

**GIVEN NAMES**

Home Address

Postcode

Mailing Address

Postcode

Phone: Mobile

Private ( )

Business

Email

Date of Birth

Age

Sex - ☐ M ☐ F

**(circle applicable)** Married or De Facto / Never Married

Widowed / Divorced / Permanently Separated / Single

Country of Birth

Religion

Occupation

Language spoken at home

Do you require an interpreter?

Aboriginal ☐ Yes ☐ No Torres Strait Islander ☐ Yes ☐ No

**MEDICARE NO.**

**Ref No.**

**Expiry. Date.**

**Pension / HCC No.**

**Veteran Affairs No.**

Type of card

Gold / White

**REFERRING DOCTOR DETAILS**

Name

Address

Postcode

Telephone

Referral Date

Provider No.

**Date aware of present symptoms**

**Date consulted doctor for symptoms**

**PRIVATE HEALTH INSURANCE DETAILS**

Name of Contributor

Health Fund

Membership No.

Table

Excess (if known)

☐ **NO HEALTH FUND / INSURANCE COVER/ SELF INSURED**

**NEXT OF KIN**

Name

Relationship to

Address

Phone

Mobile

**CARER/PERSON COLLECTING YOU**

Name

Relationship to

Mobile

Phone

Have you been hospitalised in the last 28 days

☐ Yes ☐ No If so where?.....

Is your operation necessary because of an accident ☐ Yes ☐ No

Workers Compensation ☐ Yes ☐ No

If yes, complete additional form ☐

**PERSONAL PRIVACY STATEMENT AND CONSENT**

I hereby consent to the collection and use of my personal information for the purpose of my care and well-being and in accordance with reporting requirements under legislation.

**Patient Signature**

Date

**INFORMED FINANCIAL CONSENT**

Our fees are well below the recommended AMA Rate.

I understand the Patient Estimate of Cost is based on the information given regarding my procedure at pre-admission and is subject to change according to the actual procedure performed.

I agree to allow the Clinic to contact my health fund on my behalf.

**I understand that I am responsible for payment of the Account, in the event my Health Fund or Insurer does not meet the costs incurred.**

**Patient / Guardian Signature**

Date

Payment on admission may be made by cash, bank cheque, credit cards (Visa / Mastercard) or Eftpos. Personal and business cheques are not accepted. Thank you for your understanding.

PATIENT INFORMATION FORM

# The Sydney Clinic for Gastrointestinal Diseases

Patient Name .....

AFFIX LABEL HERE

## MEDICAL HISTORY

TO BE COMPLETED BY PATIENT

Have you had or do you have any of the following? Please tick YES or NO. If yes, elaborate below.

Diabetes..... Yes ☐ No ☐ Stroke..... Yes ☐ No ☐ High blood pressure . Yes ☐ No ☐  
If Yes: Tablets, ☐ Insulin .... ☐ Epilepsy or Fits..... Yes ☐ No ☐ Heart attack..... Yes ☐ No ☐  
Kidney Disease .... Yes ☐ No ☐ Productive Cough ..... Yes ☐ No ☐ Angina/Chest Pain... Yes ☐ No ☐  
Hepatitis ..... Yes ☐ No ☐ Reflux ..... Yes ☐ No ☐ Heart Disease ..... Yes ☐ No ☐  
HIV ..... Yes ☐ No ☐ Excessive Bleeding/Bruising . Yes ☐ No ☐ Heart murmur ..... Yes ☐ No ☐  
TB ..... Yes ☐ No ☐ Antiplatelet therapy ..... Yes ☐ No ☐ Heart valve damage . Yes ☐ No ☐  
Dementia ..... Yes ☐ No ☐ Warfarin therapy ..... Yes ☐ No ☐ Pacemaker ..... Yes ☐ No ☐  
Confusion..... Yes ☐ No ☐ Respiratory disorders.... Yes ☐ No ☐ Prosthetic Device .... Yes ☐ No ☐  
Mental health issues.. Yes ☐ No ☐ Asthma..... Yes ☐ No ☐ Do you use recreational drugs. Yes ☐ No ☐  
Autism..... Yes ☐ No ☐ Sleep Apnoea ..... Yes ☐ No ☐ Weight .....kg Height .....cm

Comments / further information.....

Have you had any surgery? Yes ☐ No ☐ Specify .....

Have you a history of infections i.e. MRSA, Golden Staph, VRE? Specify:.....

Have you ever seen a Heart Specialist? Yes ☐ No ☐ Specify .....

Have you had a reaction to a previous anaesthetic? Yes ☐ No ☐ Date / Year of last Anaesthetic: .....

Anaesthetic reaction details .....

**ALLERGIES OR ADVERSE DRUG REACTIONS (specify):**

Have you had a recent fall injury? (in last 12 months) Yes ☐ No ☐ Do you require assistance when walking or need walking aids? Yes ☐ No ☐

Do you have compromised skin integrity? (eg. Ulcers, wounds, tears or pressure injuries) No ☐ Yes ☐

Do you have an Advance Care Directive or treatment limiting order? No ☐ Yes ☐ If yes, bring a copy on admission.

Do you smoke? Yes ☐ No ☐ How many a day?..... (includes last month) Have you ever smoked? Yes ☐ No ☐

How many glasses of alcohol per day do you drink? ..... (standard drinks)

Is there a family history of bowel cancer? Yes ☐ No ☐ Specify relation:.....

Do you have a history of colonic polyps? Yes ☐ No ☐ Year of last colonoscopy?.....

History of Mastectomy? Yes ☐ Left / Right No ☐ Could you be pregnant? Yes ☐ No or N/A ☐

ALL PATIENTS Please list all current medication or tablets you are taking including herbal or over the counter therapies.

Medication Name	Dosage / Frequency	Reviewed / Signed by RN

I agree that the above is a true & correct record: Signature of Patient/Guardian ..... Date .....

MEDICAL HISTORY

# The Sydney Clinic for Gastrointestinal Diseases

## CONSENT FORM

### PATIENT CONSENT

To be completed by Patient / Parent or Legal Guardian

I, ....., request understand and consent that the following procedure be performed .....

Following a discussion of my present condition, I accept the professional opinion of

Dr. .... that is the appropriate procedure / treatment for my condition.

I understand the risks, benefits, and alternatives of the procedure and these have been explained to me.

I have received written information about the preparation, procedure, the anaesthetic and post procedure care, which were discussed and explained to me.

I accept the possible risks associated with this procedure / treatment. I have had the opportunity to ask questions and I am satisfied with the explanation and the answers given to me.

I agree to such further or alternative treatment as may be found necessary as a consequence of such a procedure.

I also request and consent to the administration of anaesthetics, medicines, blood transfusions or other forms of treatment normally associated with this operation/procedure.

I understand that drowsiness may persist for several hours after sedation. I will not drive a car, or drink alcohol and will avoid making important decisions (eg. signing of legal documents) until the next day.

**Following the procedure I will have a responsible adult to accompany and supervise my return home and I have made arrangements for this.**

I understand that I may withdraw my consent at anytime prior to the procedure and/or treatment.

(If required); I do not consent to: ☐ Blood Transfusion ☐ Treatment limiting plans (specified).....

Practitioner acknowledgment / Signature required

SIGNATURE OF PATIENT / GUARDIAN ..... DATE .....

### PROVISION OF INFORMATION TO THE PATIENT To be completed by the Medical Practitioner

I, Dr ..... have described the procedure and provided written information including the nature, expected results and possible risks of the preparation/operation/procedure. I have discussed the alternatives and given the opportunity for questions to be answered.

SIGNATURE OF SPECIALIST ..... Date:.....

Interpreter required: ☐ No ☐ Yes, SIGNATURE OF INTERPRETER ..... Date:.....

Specific pre-operative instructions .....

Requires pre-operative ☐ Anaesthetic Consult ☐ CXR ☐ ECG ☐ Block

### DISCHARGE PLANNING

To be completed by Patient

This information is necessary in order to plan a safe return home

Are you >75 years Yes ☐ No ☐ Live Alone Yes ☐ No ☐

Are you solely responsible for the care of another person at home Yes ☐ No ☐

Do you currently receive assistance with any aspect of day to day living Yes ☐ No ☐

CONSENT FORM

# My healthcare rights

This is the second edition of the **Australian Charter of Healthcare Rights**.

These rights apply to all people in all places where health care is provided in Australia.

The Charter describes what you, or someone you care for, can expect when receiving health care.

## I have a right to:

### Access

- Healthcare services and treatment that meets my needs

### Safety

- Receive safe and high quality health care that meets national standards
- Be cared for in an environment that is safe and makes me feel safe

### Respect

- Be treated as an individual, and with dignity and respect
- Have my culture, identity, beliefs and choices recognised and respected

### Partnership

- Ask questions and be involved in open and honest communication
- Make decisions with my healthcare provider, to the extent that I choose and am able to
- Include the people that I want in planning and decision-making

### Information

- Clear information about my condition, the possible benefits and risks of different tests and treatments, so I can give my informed consent
- Receive information about services, waiting times and costs
- Be given assistance, when I need it, to help me to understand and use health information
- Access my health information
- Be told if something has gone wrong during my health care, how it happened, how it may affect me and what is being done to make care safe

### Privacy

- Have my personal privacy respected
- Have information about me and my health kept secure and confidential

### Give feedback

- Provide feedback or make a complaint without it affecting the way that I am treated
- Have my concerns addressed in a transparent and timely way
- Share my experience and participate to improve the quality of care and health services



PUBLISHED JULY 2019



## Parking

The Clinic has restricted parking for disabled persons for drop off or collection only. Ring in advance to arrange access. There is meter parking in the surrounding streets or parking stations at Eastgate (off Spring St) or Waverley Library (off Ebley St) which offer a reasonable hourly rate.

## Accounts

The Clinic is a Private Same Day Hospital. Contract agreements are in place with most health funds including Veteran Affairs (DVA).

### 1. Accommodation and Theatre Fees

There are multiple levels & types of health insurance. We strongly advise you to check with your health fund regarding your level of cover:

- a) that it adequately covers the cost of the procedure and accommodation.
- b) if you have an excess it is payable on admission or if you have paid it recently at another hospital, please bring your receipt with you.

Payment may be made by cash, eftpos or credit card (Visa / Mastercard). Personal cheques not accepted.

Our Staff will be happy to assist you with any questions about costs etc.

If you have been a member of the fund for less than 12 months, your fund may not pay for the cost of the admission. For example, if your condition or any symptoms of your condition existed prior to your joining. If there is a question regarding pre-existing symptoms your health fund has the option to obtain details in this regard from your GP or Specialist.

- If you are in a health fund, we will claim from the fund on your behalf. **You will be required to pay, at the time of admission, those costs not covered by your health fund eg. excess, co-payment or gap.**
- Repatriation (DVA) patients - the Clinic will lodge a claim on your behalf.
- Uninsured patients - You will be given a quote for the accommodation and theatre fees. This is payable at the time of admission. Please note that accommodation and theatre fees are not claimable from Medicare.

### 2. Specialist Fees

Discuss this fee with your Specialist's secretary. There maybe an 'out of pocket' cost.

### 3. Anaesthetic Fees

Anaesthetic fees are separate to Specialist and Clinics fees. Contact the clinic. There maybe an 'out of pocket' cost.

### 4. Pathology Fees

These costs are claimable from Medicare and your health fund and there may be an 'Out of pocket' cost.

**The Clinic is an Australian Council on Healthcare Standards (ACHS) accredited private day procedure centre**

The ACHS mission is to improve the quality and safety of health care.

The principles upon which all ACHS programs are developed reflect the characteristics displayed by an improving organisation are:

- *patient centred care*
- *strong leadership*
- *a culture of improving*
- *evidence of outcomes*
- *striving for best practice.*

Accreditation is public recognition of achievement of accreditation standards by a health care organization demonstrated through an independent external peer assessment of that organization level of performance in relation to the standards and a commitment to continuous improvement in the quality of care, service and safety.

*The Sydney Clinic for Gastrointestinal Diseases  
ACHS accredited until 2020*

The CEO, Management, Medical Specialists and all staff at the Clinic are involved and committed to delivering "**safety, quality & performance**" in patient care and all areas of service. ACHS Accreditation is a significant achievement as it serves as a sign to our patients and community that the Clinic meets a high standard in care, service and safety.

## PATIENT FEEDBACK

Please complete a patient questionnaire or suggestions form to assist us improving our service. Available throughout the Clinic.

## COMPLAINTS PROCESS

Please contact the Quality Manager, Director of Nursing or Practice Manager if you have any concerns, problems or suggestions during your stay. If you wish to lodge a complaint contact any of our staff. Alternatively, contact the NSW Health Care Complaints Commission: 1800 043 159 or <https://www.hccc.nsw.gov.au/>

## CONSUMER FOCUS GROUP

If you are interested in providing us with input and feedback on our services please contact the Quality Manager. The clinic holds an annual meeting to actively seek community engagement.

If you would like further information please contact our Quality Manager Tel: (02) 9369 3666 or email [nursing@nssc.com.au](mailto:nursing@nssc.com.au) / [patientfeedback@nssc.com.au](mailto:patientfeedback@nssc.com.au)

Your **follow up appointment is important** and is part of the management of your condition. If you are unable to attend, please phone to cancel and reschedule. Failure to keep your appointment may interfere with your management.

**THE CLINIC HAS A NO SMOKING POLICY**

## Consulting Specialities

Maxillofacial Surgery, Gastroenterology, Hepatology, & Ophthalmology.

## On-Site Services

Pathology laboratory - NATA accredited. Full pathology services available including urgent cross matching of blood.

## Further Information

If you have any questions or would like more details of our services or facilities, please contact the Clinic.

Pre-admission forms and Bowel preparation instructions are available on the website

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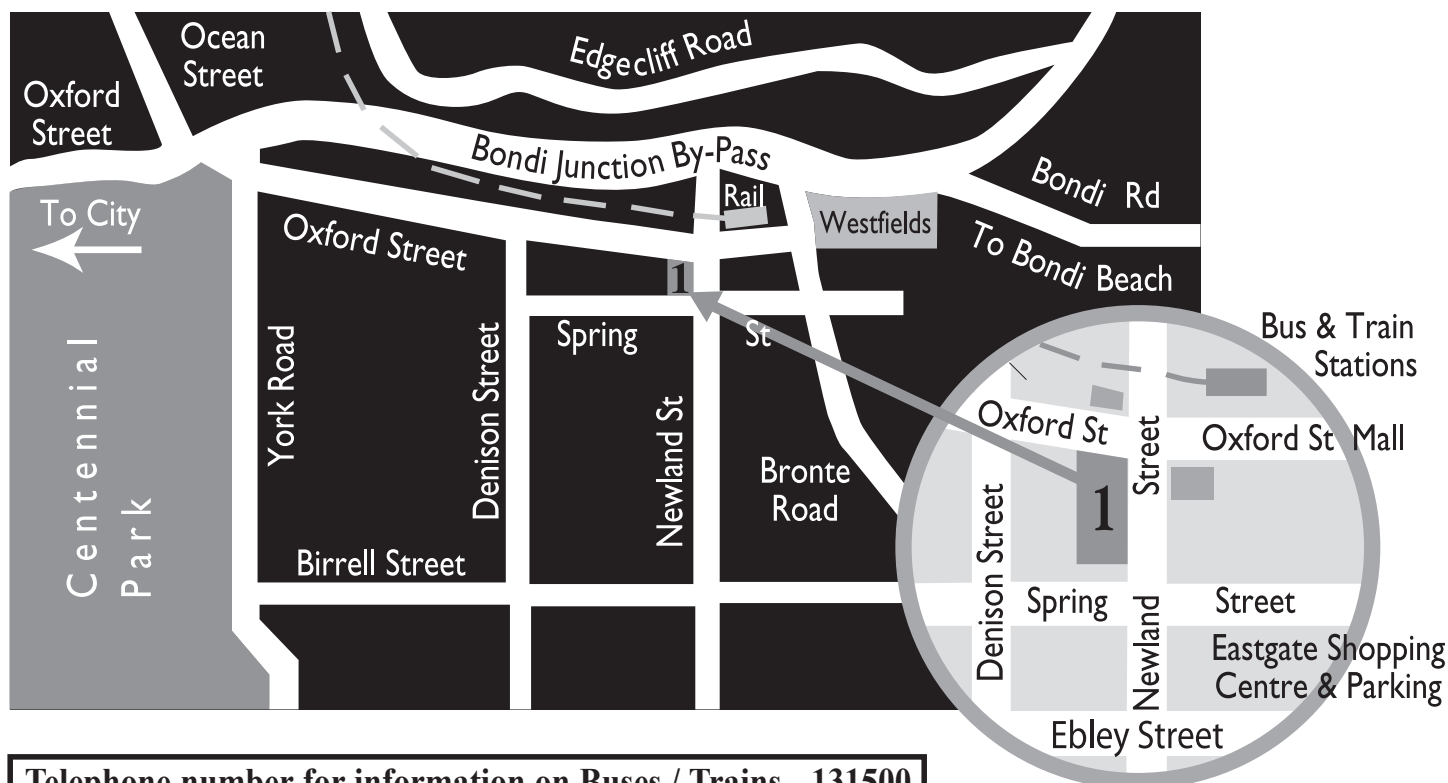
Website: [www.nssc.com.au](http://www.nssc.com.au)

Director/Owner:

Dr E.A. Wegman

M.B., B.S. (Hons) (N.S.W.) Ph.D (Syd) F.R.A.C.P.

ABN 42 056 367 492 ACN 056 367 492



### Telephone number for information on Buses / Trains - 131500

or visit [www.transportnsw.info](http://www.transportnsw.info) to plan your trip

#### Buses to Bondi Junction:

from Circular Quay	-	Route 380, (or T4 Train)
from Coogee Beach	-	Route 313, 314, 353, 360
from Randwick	-	Route 314, 316, 317, 348, 357, 400
from Maroubra/East Gardens	-	Route 400, 316
from Dover Heights	-	Route 380, 379, 386, 387