

The Newland Street Specialist Centre

The Sydney Clinic for Gastrointestinal Diseases

Level 10, 1 Newland Street
Bondi Junction NSW 2022
Telephone No. (02) 9369 3666
Fax No. (02) 9369 1247
Email: admissions@nssc.com.au
Website: 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.

Thank you for choosing us, we hope your stay will be as 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 the clinic staff.

2-3 weeks notice is required to organise an interpreter.

Pre-Admission Information

Please bring to your admission

- Your completed 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.

Allow a **minimum** of 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 to that time).**

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 packet 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 permitted). We cannot accept responsibility for jewellery worn during your admission.
- **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.**
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.
- **Follow all discharge instructions (verbal and written) given to you by staff.**

You must not (until the following day).

- Make any legally binding decisions
- Drive a motor vehicle
- Drink alcohol
- Return to work

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

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

The Sydney Clinic for Gastrointestinal Diseases

PERSONAL DETAILS

TO BE COMPLETED IN FULL BY PATIENT

Title (Mr, Mrs, Ms, Miss, Dr, Prof, Other.) _____ (circle)

SURED

SURNAME

NEXT OF KIN

GIVEN NAMES

Name

Home Address

Relationship to patient

Postcode

Address

Mailing Address

Mobile

Phone

Postcode

CARER/PERSON COLLECTING YOU

Phone: Mobile

Name

Private/Business ()

Relationship to patient

Email

Mobile

Phone

DOB _____ Age _____ Sex M F Non-Binary

Have you been hospitalised in the last 28 days

Married or De Facto / Never Married / Widowed /

Yes No If so, where?

Divorced / Permanently Separated (circle applicable)

Is your operation necessary because of an accident Yes No

Country of Birth

Religion

Workers Compensation Yes No

Occupation

If yes, complete additional form

Language spoken at home

Do you require an interpreter?

PERSONAL PRIVACY STATEMENT AND CONSENT

Are you of Aboriginal or Torres Strait Islander origin?

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. Including access to My Health Record (MHR). TGA approved AI systems may be used to enhance your care.

No Aboriginal Torres Strait Islander

Both Aboriginal and Torres Strait Islander

Declined to answer

MEDICARE NO.

Patient Signature

Date

Ref No.

Expiry Date

Pension / HCC No.

INFORMED FINANCIAL CONSENT

Veteran Affairs No. _____ Type of card _____ Gold /White

Our fees are well below the recommended AMA Rate.

REFERRING DOCTOR DETAILS

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.

Name

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

Address

Postcode

Telephone

Referral Date

Provider No.

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.

Date aware of present symptoms

Date consulted doctor for symptoms

PRIVATE HEALTH INSURANCE DETAILS

Health Fund

Patient/Guardian Signature

Date

Membership/Policy No.

NO HEALTH FUND / INSURANCE COVER / SELF IN-

Payment on admission may be made by cash, eftpos or credit card (Visa/Mastercard). Personal Cheques and AMEX not accepted. Thank you for your understanding.

PATIENT INFORMATION FORM

The Sydney Clinic for Gastrointestinal Diseases

MEDICAL HISTORY

Patient Name

AFFIX LABEL HERE
TO BE COMPLETED BY PATIENT

Do you have, or have you ever had, any of the following:

Diabetes.....Yes <input type="checkbox"/> No <input type="checkbox"/>	Dementia/confusion.....Yes <input type="checkbox"/> No <input type="checkbox"/>	Stroke.....Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes tablets <input type="checkbox"/> insulin <input type="checkbox"/>	History of Delirium.....Yes <input type="checkbox"/> No <input type="checkbox"/>	High Blood Pressure.....Yes <input type="checkbox"/> No <input type="checkbox"/>
Kidney Disease.....Yes <input type="checkbox"/> No <input type="checkbox"/>	Mental Health Issues.....Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Attack.....Yes <input type="checkbox"/> No <input type="checkbox"/>
Autoimmune Disease.....Yes <input type="checkbox"/> No <input type="checkbox"/>	specify.....	Angina/Chest Pain.....Yes <input type="checkbox"/> No <input type="checkbox"/>
specify.....	Prosthetic Devices.....Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Disease.....Yes <input type="checkbox"/> No <input type="checkbox"/>
Epilepsy or fits.....Yes <input type="checkbox"/> No <input type="checkbox"/>	specify.....	Heart Murmur.....Yes <input type="checkbox"/> No <input type="checkbox"/>
Asthma.....Yes <input type="checkbox"/> No <input type="checkbox"/>	Walking aids.....Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Valve Damage.....Yes <input type="checkbox"/> No <input type="checkbox"/>
Respiratory Disorders.....Yes <input type="checkbox"/> No <input type="checkbox"/>	specify.....	Pacemaker.....Yes <input type="checkbox"/> No <input type="checkbox"/>
TB.....Yes <input type="checkbox"/> No <input type="checkbox"/>	Recent fall.....Yes <input type="checkbox"/> No <input type="checkbox"/>	Antiplatelet/warfarin therapy...Yes <input type="checkbox"/> No <input type="checkbox"/>
Cough (current).....Yes <input type="checkbox"/> No <input type="checkbox"/>	when.....	Excessive bruising/bleeding...Yes <input type="checkbox"/> No <input type="checkbox"/>
Reflux or heartburn.....Yes <input type="checkbox"/> No <input type="checkbox"/>	Ulcers, wounds, pressure injuries...Yes <input type="checkbox"/> No <input type="checkbox"/>	Last seen by Heart Specialist
Sleep Apnoea.....Yes <input type="checkbox"/> No <input type="checkbox"/>	detail.....	Date/year.....

Have you had any surgery or a blood transfusion? Details.....

Date/year of last anaesthetic.....Adverse anaesthetic reactions?

Infection History

Do you have HIV or hepatitis B or C..... Yes No

Have you ever had an antibiotic resistant infection eg MRSA, VRE, CPE..... Yes No

Have you been overseas in the last 6 weeks or had an overnight stay in an OS hospital in the last year?..... Yes No

In the last 14 days have you been exposed to anyone with an infectious disease eg chicken pox, measles, flu, coronavirus? Yes No

Details.....

Family/Personal History

Is there a family or personal history of bowel cancer? Yes No Specify relation.....

Do you have a history of colonic polyps? Yes No Date of last colonoscopy

History of breast cancer and/or mastectomy? Yes No If yes left or right

Could you be pregnant? Yes No NA

Social History

Do you drink alcohol? Yes No How many standard drinks per day?

Do you smoke? Yes No How many per day..... Have you ever smoked? Yes No Year/ date ceased

Do you use recreational drugs? Yes No Specify.....

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

Height.....Weight.....BMI.....

ALLERGIES OR ADVERSE DRUG REACTIONS (detail): Nil Known tick if no allergies

.....

.....

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

Medication Name	Dosage	Medication Name	Dosage	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 this 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 and the required preparation. 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, 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 (e.g. 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:.....

If required, signature of interpreter Date:.....

Specific pre-operative instructions

DISCHARGE PLANNING

To be completed by Patient

This information is necessary 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 Reviewed by RN/DR Yes

AFFIX PATIENT LABEL HERE

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



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 Shopping Centre or Waverley Library 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 and 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 maybe 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 strengthen safe, quality healthcare by continuously advancing standards and education nationally and internationally.

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

- *A consumer focus*
- *Effective leadership*
- *Continuous improvement*
- *Evidence of outcomes*
- *Striving for best practice*

Accreditation is public recognition by a health care accreditation body of the achievement of accreditation standards by a health care organisation, demonstrated through an independent external peer assessment of that organisation's level of performance in relation to the standards.

The Sydney Clinic for Gastrointestinal Diseases is ACHS accredited

The CEO, visiting medical specialists, management and staff are committed to the principles of accreditation and practice safety and quality in health care by adopting the standards developed by The Australian Commission on Safety and Quality in Health Care.

PATIENT FEEDBACK

At the SCGID we welcome your feedback and suggestions for improvement.

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. If you feel that your complaint has not been dealt with satisfactorily you can contact the NSW Health Care Complaints Commission: 1800 043 159 or <https://www.hccc.nsw.gov.au/>

CONSUMER FOCUS GROUP

If you would like to participate in the consumer focus group providing suggestions for improvement and giving feedback on our services please contact the Quality Manager.

For further information contact our Quality Manager:

Telephone: (02) 9369 3666

Email: nursing@nssc.com.au/patientfeedback@nssc.com.au

FOLLOW UP

Your follow up appointment is an important part of the management of your health. If you are unable to attend a follow up appointment, please phone to cancel and reschedule. Failure to do so may impact on your health outcomes.

THE CLINIC HAS A NO SMOKING POLICY

Consulting Specialities

Gastroenterology, Hepatology, Inflammatory Bowel, Colorectal Surgery, & Endocrine.

On-Site Services

Pathology laboratory - NATA accredited. Full pathology services available.

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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Incorporating

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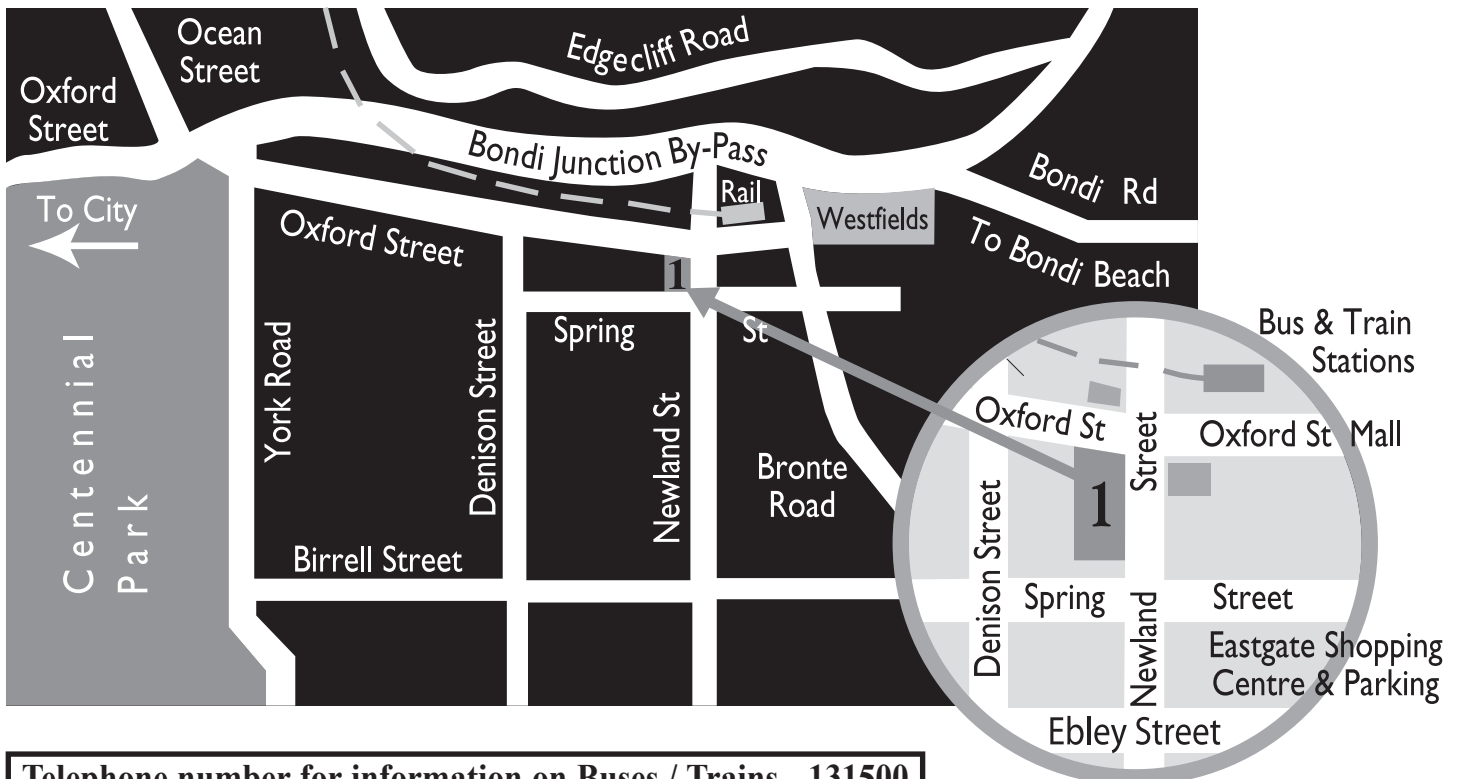
Website: www.nssc.com.au

Director/Owner:

A/Prof 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.transportsw.info to plan your trip