Braemar Hospital

Your choice for excellence

BRAEMAR HOSPITAL TO AFFIX
PATIENT DETAILS LABEL HERE

ENDOSCOPY SERVICE BDH-ES/03

As advised by your Surgeons rooms

Date of Admission: ..... **Time of Admission:** .....

Nothing to eat from: ..... Nothing to drink from: .....

Please complete this form online:

1. Once completed, save the completed form as a pdf
2. Email the pdf to admissions@braemarhospital.co.nz at least 1 week prior to your admission

Legal Surname: Miss ◉ Ms ○ Mrs ○ Mr ○ Dr ○ Mx ○

Legal First Names: Preferred Name:

Date of Birth: Country of Birth:

Gender/Pronouns: Are you a permanent NZ resident?: Yes ○ No ○

Ethnicity:

Home Address:

Postal Address:
(if different to home)

Phone 1: Phone 2:

Email: Email Invoice? Yes ○ No ○

Surgeon or Specialist:

GP's Name: Practice:

Next of Kin

Name: Relationship:

Address:

Contact Phone Numbers:

Contact Person (if different from above)

Name: Relationship:

Address:

Contact Phone Numbers:

Medical Insurance Company: Approval Number:

ACC Approval Number:

Have you been treated in this hospital previously? Yes ○ No ○ Name previously used:

Do you require "Boarder" accomodation for an adult with a child patient? Yes ○ No ○

Braemar Hospital is unable to accept any responsibility for loss or damage to valuables or money belonging to patients.

Information and Consent Form

About Gastroscopy

Gastroscopy is a visual examination of the lining of the upper gastrointestinal tract using a narrow, flexible tube called a gastroscope. The image is transmitted to a computer screen, which the specialist views. Special instruments can be passed down the gastroscope to obtain a biopsy (a tiny tissue sample) or remove polyps. All samples are sent to the laboratory for analysis. The gastroscope visualises the oesophagus, stomach and duodenum (beginning of the small bowel).

A gastroscopy is normally a safe procedure and complications are rare. The risk of a significant complication is about 1 in 5,000 procedures. As with most procedures there are some risks.

These are rare but include:

- Allergic reaction to the sedative or anaesthetic drugs. This is uncommon.
- Major bleeding.
- There is a risk that an abnormality may not be detected despite gastroscopy being considered a very accurate test.
- Perforation (making a hole in the upper gastrointestinal tract).

About Colonoscopy

Colonoscopy is a visual examination of the large bowel (colon) using a narrow flexible tube called a colonoscope. The colonoscope has a wide angled camera in the tip and when this is passed into your bowel an image of the inner lining is captured. This image is transmitted to a computer screen, which the specialist views. By advancing the colonoscope along the length of the bowel, the whole bowel can be viewed. During the examination tiny samples of tissues called biopsies may be taken, and any polyps removed, for analysis under the microscope.

A Colonoscopy is normally a safe procedure and complications are rare. The risk of a significant complication is about 1 in 1000 procedures. As with most procedures there are some risks.

These are rare but include:

- Allergic reaction to the sedative or anaesthetic drugs. This is uncommon.
- Bleeding if a tissue sample is taken for testing. This usually stops on its own or can be controlled through the colonoscope.
- There is a risk that an abnormality may not be detected despite colonoscopy being considered a very accurate test.
- Perforation (tearing of the bowel wall).

About Banding of Haemorrhoids

This is an effective treatment for internal haemorrhoids which often bleed or prolapse through the anus. A small scope is inserted into the anus and a specialised instrument is used to apply rubber bands over the internal haemorrhoids. The rubber band cuts off the blood supply to the haemorrhoids which usually drop off, along with the band, after 4-7 days.

Complications are very uncommon, however if bleeding becomes severe you should contact your specialist immediately.

Very rarely severe infection can occur, (less than 1 person in 100,000) if you suddenly feel unwell with fever and severe anal pain you must get medical attention immediately as treatment with antibiotics is urgent.

General Information

- On arrival for the above procedure, you may be asked to wait in the reception area.
- **PLEASE NOTE** the time given to you by your specialist's rooms is your admission time and is not the time of your actual procedure.
- The actual investigation will be done on a bed, where you will remain until you recover from the sedation.
- You **MUST NOT** drive for 18 hours after the procedure if you have sedation and 24 hours after the procedure if you have a general anaesthetic. It is important that you arrange for someone to drive you home following your procedure and have a responsible adult stay with you overnight. (You are not permitted by law, to drive yourself).
- Please continue your usual medications unless discussed with your specialist.

I (full name) .....

agree that (procedure) .....
be performed on me (or full name of my child/relative/ward)

I have been able to discuss this with my specialist: ..... whose signature appears below. He/she has explained to me the reasons for and expected risks of the procedure relating to my clinical history and condition. I have had adequate opportunity to ask questions and have received all the information I want and I agree to the procedure/treatment. I understand that I am welcome to ask for more information if I wish, and my consent may be withdrawn at any time.

Signed (patient/representative): ..... Date .....

Signed (specialist): ..... Date .....

General Privacy Statement

We collect your health information to provide you with appropriate care and to monitor quality.
We share this information with other health care providers and agencies involved in your care.
We treat your information as confidential and ensure that it is kept secure and only accessed by authorised persons.
You have the right to request access to your records and to request correction of the information. Information may be supplied to family, support people or other agencies if you give us your permission or disclosure is authorised by law.
Our full Privacy Statement is available on our website or from the hospital reception.

Account Information

Statement to be signed by patient before surgery.

I understand and agree that:

- Unless my specialist has advised me otherwise, any hospital fee figure given to me is an estimate only. For example, a procedure may take a shorter or longer time to complete, or, you may require a longer stay in hospital than originally estimated. In most cases though your specialist will be able to provide you with a reasonably accurate estimate.
- I am responsible for the payment of all costs associated with my stay at Braemar Hospital (excluding those which are paid for by another organisation such as ACC, an insurance company, a district health board etc).
- If I am an ACC patient, I will be invoiced for costs not paid by ACC, such as telephone calls, room upgrades, extra meals etc.

Before the procedure

- I give permission for Braemar Hospital to check on my current credit status before (or after) my procedure.
- If I have no insurance cover or no prior approval from my insurance company, Braemar Hospital may reserve the right to insist that I pay an estimate of the cost of my procedure in advance. (Braemar Hospital recommends that you obtain prior approval from your insurance company).

Invoice and payment

Unless another organisation such as ACC or a district health board are paying the full amount, I will receive invoices from:

- Braemar Hospital, the specialist, the anaesthetist (where applicable), and any other services such as physiotherapy (where applicable).

If I have insurance cover for my procedure, I agree to promptly:

- Send the invoice to the insurance company.
- Pay for all of the cost of the procedure that is not paid by my insurance company.

If I do not have insurance cover:

- I will pay the account in full promptly on receipt of invoice.

Overdue accounts

- I agree that I have sufficient funds in place to meet the costs of my procedure at Braemar Hospital on the due date.

If I do not pay on the due date:

- I will pay the interest charged by Braemar Hospital on any amount unpaid after the due date.
- The interest rate will be 1% per month of the amount unpaid at the end of each month.
- Braemar Hospital may instruct their debt collector or solicitor to recover any amount unpaid after the due date.
- I will pay for all of the debt collection costs incurred by Braemar Hospital or their debt collector and/or legal costs on a solicitor/client basis

I, Patient ◯ Parent ◯ Caregiver ◯

.....

have read and accept the above terms.

Signature: .....

Date: .....

(to be signed at Braemar Hospital)

BRAEMAR HOSPITAL TO AFFIX
PATIENT EMAIL LABEL HERE

Please complete this section prior to admission

ALLERGY STICKER

Do you have any allergies? If **YES** please provide details below.

.....

.....

Health Questionnaire - To be completed by patient

Have you ever had or do you have any of any of the following?

	Yes	No
Asthma / Bronchitis	○	○
Sleep Apnea	○	○
Hypertension (High BP)	○	○
Infectious Diseases (ESBL, MRSA, TB, Hepatitis, HIV)	○	○
Epilepsy	○	○
Diabetes	○	○
Glaucoma	○	○
Metalware / Prosthesis (joint) / Pacemaker / Implants	○	○
Heart Problem (heart valve / heart attack)	○	○
Liver / Kidney disease	○	○

	Yes	No
Blood clotting disorders	○	○
Possibility of pregnancy	○	○
Have had a gastroscopy / colonoscopy before?	○	○
Other (radiotherapy / chemotherapy)	○	○
Do you or have you ever smoked /vaped?	○	○
If yes, how much?		
For how long?		
When did you give up?		
Do you drink alcohol?	○	○
If yes, how many units weekly (1 standard glass wine or 1/2 glass beer = 1 unit)		

	Yes	No
Do you use recreational drugs?	○	○
If yes, what do you use?		
How often do you use?		
Wear glasses / contact lenses	○	○
Other eye conditions	○	○
Hearing difficulties	○	○
Any special dietary requirements?	○	○
Do you have a disability?	○	○
If your surgery requires the removal of body parts, would you like them returned to you if possible?	○	○

If you answered **YES** to any of the questions above, please provide details, including treatment.

.....

.....

Have you had any illness/surgery in the past? If **YES**, please provide details.

.....

.....

Current Medication

Current Medications (please list):

Are you taking any blood thinning medication? Yes ○ No ○

☐ Warfarin ☐ Aspirin ☐ Dabigatran (Pradaxa) ☐ Other:

If Yes, when did you last take them?: INR Result (if applicable):

Pre-Procedure Nursing Assessment - To be completed by admitting Nurse

Weight: BP: HR: SaO_2:

Last Food: Last Fluid: BGL result (if applicable):

Coag-check result (if applicable): Bowel Prep completed:

Patient has: ☐ Own teeth ☐ Crowns and Caps ☐ Partial Plate ☐ Hearing Aids ☐ Full Dentures ☐ Dental Wire

☐ Clear ☐ Muddy Colour:

Enemas Required:

Number: Result:

Have you taken your usual medication today?: Yes ☐ No ☐ Consent signed: Patient ☐ Specialist ☐

Patient to be collected by: Phone:

Valuables sent home with family member? Yes ☐ No ☐ Follow up phone call? Yes ☐ No ☐

Valuables placed in bottom draw in treatment room? Yes ☐ No ☐ Phone number:

Nurse Name: Signature:

Ward Observations

Ward Nursing Notes

Dx BP:

Time of Discharge: Signature:

Discharge Checklist

- ☐ Tolerating Fluids/light diet
- ☐ Pain controlled
- ☐ Post-procedure instructions given
- ☐ Copy of Endoscopy report given
- ☐ Referral Form sent/ copy to patient
- ☐ Prescription (if applicable)
- ☐ Valuables returned to patient (if applicable)
- ☐ IV cannula removed

Follow up phone call

Sample Initials – Administrators/Other

Name (Printed):	REG No.	Initials	Name (Printed):	REG No.	Initials

PLEASE AFFIX PATIENT DETAILS LABEL HERE

TRACEABILITY STICKERS

TIME IN:	TIME OUT:

ENDOSCOPE NUMBER

Procedure

Allergy: ☐ Yes ☐ No

- ☐ Gastroscopy
- ☐ Mouthguard
- ☐ Dilatation (Balloon / Gilliard)
- ☐ Colonoscopy
- ☐ Flexible sigmoidoscopy
- ☐ Banding haemorrhoids / Varices
- ☐ EUS
- ☐ FNA
- ☐ ERCP
- ☐ Tattooing
- ☐ EMR / Other

IV Cannula Insertion

☐ R) ACF ☐ L) ACF Other site: .....

☐ R) Hand ☐ L) Hand Size: .....

Time: ..... Sign: .....

Medication Administered During Procedure

DRUG	TIME	DOSE	TIME	DOSE	TIME	DOSE	TIME	DOSE	Nurse 1	Nurse 2	Specialist
IV Midazolam (mg)											
IV Fentanyl (mcg)											
IV Hyoscine N-Butyl Bromide (mg)											
Lidocaine Spray											
IV Fluids											

Biopsies/Polyps

	Bx	P		Bx	P		Bx	P
Oesophagus	☐	☐	H Pylori (Clo Test/HUT Test)	☐	☐	Descending	☐	☐
GO Junction	☐	☐	Terminal ileum	☐	☐	Left colon	☐	☐
Gastric	☐	☐	Caecum	☐	☐	Sigmoid	☐	☐
Antrum	☐	☐	Ascending	☐	☐	Rectum	☐	☐
Pylorus	☐	☐	Right colon	☐	☐	Other:		
Duodenum 1	☐	☐	Hepatic flexure	☐	☐	.....	☐	☐
Duodenum 2	☐	☐	Transverse	☐	☐	.....	☐	☐
Disaccharides	☐	☐	Splenic flexure	☐	☐	.....	☐	☐

Time															
O^2															
SaO^2															
Resps															
220															
210															
200															
190															
180															
170															
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10															

Endoscopy Nursing Notes

Abdominal Pressure: Yes No Name: Time Required:

Restart anti-coagulant medication - Date: Sign:

Ward Medication

Date	Medication	Dose	Route	Freq.	Dr. Signature	Nurse Signature	Nurse Signature	Time

Recovery Record

Arrival Time
Hrs

On Admission

- ☐ Unconscious
- ☐ Conscious at _____Hrs

Anaesthetic

- ☐ General
- ☐ Local
- ☐ Block
- ☐ Sedation
- ☐ No Sedation

Airway

- ☐ None
- ☐ Jaw Support
- ☐ Hudson Mask
- ☐ Optiflow
- ☐ NP
- ☐ Other

Resps

- ☐ Normal
- ☐ Shallow
- ☐ Low Rate

Time															
O^2															
SaO^2															
Resps															
220															
210															
200															
190															
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Recovery Room Discharge Comments

……

……

……

IV Luer: …… IV Fluids: ……

Nurse's Signature: …… Discharge Time: …… hrs.