



101 Clarence Street, Hamilton Lake, Hamilton | Ph: (07) 858 0772

PLEASE AFFIX PATIENT DETAILS
LABEL HERE

ENDOSCOPY SERVICE

BDH-ES/03

As advised by your Specialist rooms

Date of Admission: Time of Admission:

Nothing to eat from: Nothing to drink from:

Please complete pages 1 and 3 of this form, then either -

1. Scan and email the pages to reception@eoc.nz (please bring original with you), or
2. Drop the form to our reception team at **101 Clarence Street, Hamilton**, or
3. Post / courier the pages to us, ensuring they arrive at least **one week prior** to your admission

Contact Details

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:
Dietary Requirements: ☐ N/A ☐ GF ☐ DF ☐ VEGAN ☐ VEG
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

Medical Insurance Company: Approval Number:
ACC Approval Number:
Have you been treated in this hospital previously? ☐ Yes ☐ No Name previously used:

Endoscopy on Clarence 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 diagnostic procedure that examines the lining of the upper gastrointestinal tract. This procedure allows specialists to take a closer look at your oesophagus, stomach, and the beginning of your small intestine (duodenum). An endoscope (a thin flexible tube) is passed through the mouth, down your oesophagus and into your stomach and duodenum. Images are viewed by the Specialist. If necessary, biopsies (tissue samples) or polyps can be taken. These specimens are sent to the laboratory for analysis.

However as with most medical procedures, there are potential risks. The risk of a significant complication arising during the procedure is approximately 1 in 5,000. Potential complications include allergic reactions, bleeding, or perforation (a hole in the upper gastrointestinal tract). Despite gastroscopy being a highly accurate diagnostic test, there is also a possibility that some abnormalities may not be detected.

About Colonoscopy

Colonoscopy is a procedure that involves visually inspecting the large intestine (colon) using a narrow, flexible tube known as a colonoscope. This examination allows for a comprehensive view of the entire colon as the colonoscope is gently advanced through it. If necessary, the specialist can collect tissue samples (biopsies) or remove polyps. All samples are sent to a laboratory for analysis.

Typically, a colonoscopy is a safe procedure with infrequent complications. The likelihood of experiencing a significant complication is around 1 in 1,000 procedures. As is the case with most medical procedures, there are some risks. Although rare, these could include:

- Allergic reaction to medication during your stay.
- Despite colonoscopy being a highly accurate diagnostic test, there is a risk that some abnormalities may not be detected.
- Bleeding and/or perforation (tearing of the bowel wall)

About Haemorrhoid Banding

This procedure is effective for treating internal haemorrhoids, particularly those prone to bleeding or prolapse from the anus. It involves inserting a small scope into the anus and a specialised instrument places rubber bands around the internal haemorrhoids. These rubber bands restrict the blood supply to the haemorrhoids, causing them to detach, along with the bands, within a span of 4 to 7 days.

Complications are very rare. However, in the event of severe bleeding, you must contact your specialist and seek medical attention immediately. On extremely rare occasions (affecting less than 1 person in 100,000), a severe infection can develop.

Payment of Hospital Costs

Insured Patients

If your treatment is through the Southern Cross affiliated provider scheme, you should receive information about any potential co-payments required before you come into the hospital. For other health insurance companies, you will need to obtain prior approval before your admission.

Please note that some policies do not cover all of your medical or surgical costs. If that is the case you will need to meet the cost not covered by your insurance company.

The hospital will submit insurance claims directly with Southern Cross health insurance only. For all other health insurance companies you will need to make the claim.

If your insurance company fails to make payment for any reason then you are still responsible for making the payment in full.

Uninsured Patients

You are responsible for making payment in full within 7 days of the date of invoice. Some patients are required to pay upfront, this will be discussed as appropriate.

If your treatment is covered by Te Whatu Ora – Health New Zealand, the hospital will seek approval for your procedure on your behalf.

HEALTH QUESTIONNAIRE TO BE COMPLETED BY THE PATIENT

RELEVANT MEDICAL / SURGICAL HISTORY

Allergy Sticker

ALLERGIES & REACTIONS

Smoking Status ☐ Current ☐ Ex-Smoker ☐ Never Smoked

Have you had a previous gastroscopy/colonoscopy ☐ Yes ☐ No Glaucoma ☐ Yes ☐ No

Hospitalisation within last six months ☐ Yes ☐ No Metalware/Prosthesis(joint) ☐ Yes ☐ No

Asthma/Bronchitis ☐ Yes ☐ No Heart problems (heart valve) ☐ Yes ☐ No

Hypertension (High BP Pressure) ☐ Yes ☐ No Liver/Kidney disease ☐ Yes ☐ No

Infectious Diseases (ESBL, MRSA, Hepatitis, TB) ☐ Yes ☐ No Blood clotting problems ☐ Yes ☐ No

Epilepsy ☐ Yes ☐ No Possibility of pregnancy ☐ Yes ☐ No

Diabetes ☐ Yes ☐ No Other (radiotherapy/chemo) ☐ Yes ☐ No

Have you had any illness/surgery in the past? ☐ Yes ☐ No

If YES, please provide details

CURRENT MEDICATION (PLEASE LIST)

Are you on any Blood Thinning Medication ☐ Yes ☐ No ☐ Aspirin

☐ Warfarin ☐ Dabigatran (Pradaxa) ☐ Rivaroxaban ☐ Clopidogrel ☐ Other

If YES, when did you last take them INR Result (if applicable)

PRE-PROCEDURE NURSING ASSESSMENT - COMPLETE BY ADMITTING NURSE

Procedure: ☐ Flexi Sig ☐ Colonoscopy ☐ Gastroscopy ☐ Other Time:

RECORDINGS: BP: / Pulse: 02 Sats: BSL: Temp: Weight: Height:

Last food: Date: Time: Last drink: Date: Time:

Labels and Identification Correct: ☐ Yes ☐ No Did you drink all your bowel Prep ☐ Yes ☐ No ☐ N/A

Bowel motions ☐ Watery ☐ Lumpy ☐ Solid ☐ Yellow ☐ Brown

Enema Required ☐ Yes Number: Result:

TICK APPLICABLE: ☐ Own Teeth ☐ Partial Plate ☐ Full Dentures ☐ Crowns ☐ Caps ☐ Hearing Aid

☐ Private X-Rays ☐ Spectacles/Contact Lens ☐ Walking Stick/Aid Consent Signed: ☐ Patient ☐ Specialist

Patient to be collected by: Contact Phone No:

Nurse Notes

Gauge: Site: No. of attempts: Signature: ☐ Flushed

Nurse Name: Nurse Signature:



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ENDOSCOPY PROCEDURE RECORD

Date: Time In: Time Out:

Endoscopist: Endoscopy Nurse: Sedation Nurse:

Anaesthetist: Anaesthetic Tech: Professional visitor/s:

☐ Gastroscopy ☐ Colonoscopy ☐ Flexi Sigmoidoscopy ☐ Banding Haemorrhoids ☐ Tattooing
☐ Polypectomy ☐ EMR ☐ Clip (number)..... ☐ Botox ☐ Proctoscopy
☐ Other IV Luer ☐ Yes ☐ No

INTRA-OP

ADMINISTERED MEDICATION.

Date	Drug	TIME	DOSE	TIME	DOSE	TIME	DOSE	Given by	2nd Nurse	Doctor
	Fentanyl mcg/IV									
	Midazolam mg/IV									
	Hyoscine mg/IV									
	Lignocaine Spray PO/PR									
	IV Fluid IV									

OXYGEN THERAPY AND MEDICAL GASES

Device/delivery	Flow rate range	Signature

OBSERVATIONS

Time																				
O ²																				
SaO ²																				
Resps																				
LOC																				
Pain Score																				
220																				
200																				
180																				
160																				
140																				
120																				
100																				
80																				
60																				
40																				
20																				
0																				

BIOPSIES/POLYPS

	Bx	P		Bx	P		Bx	P
Oesophagus			H Pylori (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					

UGI Start Time: End Time:
 Colon Start Time: Withdrawal Time: End Time:

POST OP CARE INSTRUCTIONS

Restart anti-coagulant medication – Start Date: _____ Sign: _____

ENDOSCOPY TRACEABILITY STICKERS

ENDOSCOPE NUMBER	TRACEABILITY STICKERS
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Date	Recovery Medication	Dose	Route	Frequency	Doctor's Signature	Nurse's Signature	TIME

[illegible]

Vital Signs					
MPADSS	A =	B =	C =	D =	E = Total/10
Sip Test: ☐ Yes ☐ No		IV Luer:		IV Fluids:	
Nurse's Signature			Discharge Time		Hrs

LOC Guide A: Alert V: Verbal P: Painful Stimuli U: Unresponsive Pain Score 0 No pain, 1 Mild, 2 Moderate 3 Severe
Vital Signs(A) 0-2, Activity(B) 0-2, Nausea/Vomiting(C) 0-2, Pain(D) 0-2, Surgical Bleeding(E) 0-2.

WARD NOTES

Discharge Checklist

- | | |
|--|--|
| ☐ Tolerating Fluids/light diet | ☐ Referral Form sent/ copy to patient |
| ☐ Pain controlled | ☐ Prescription (if applicable) |
| ☐ Post-procedure instructions given | ☐ Valuables returned to patient (if applicable) |
| ☐ Copy of Endoscopy report given | ☐ IV cannula removed |
| | ☐ Seen by Dr ☐ Yes ☐ No |

Ward Nursing Notes

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Observations:

Time: BP: HR: SaO₂: BGL: mmol/L

Time of Discharge: Signature:

Health Professionals Initials – Prescribers/Checker

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

CONSENT TO PROCEDURE AND TREATMENT

THIS SECTION TO BE COMPLETED BY SPECIALIST

Legal Surname:

Legal First Names:

Procedure/Treatment:

☐ Sedation ☐ General ☐ Local

Risks Discussed: Bleeding 1% Perforation 0.1% Missed pathology 2%

Specialist Name:

Specialist Signature: Date:

THIS SECTION TO BE COMPLETED BY THE PATIENT (OR PARENT / GUARDIAN)

I request and agree for the procedure/treatment described above be performed on myself/my child (delete one).

I confirm that I have received a satisfactory explanation of the reasons for, risks and likely outcomes of the procedure/treatment, and the possibility and nature of further related treatment should any complications arise including a return to theatre.

I have been informed of both benefits and risks including rare but serious risks. I understand that if essential, further or alternative operative/procedural measures may be undertaken during the course of the procedure.

I have had the opportunity to ask questions and may seek more information at any time.

I give permission for Endoscopy on Clarence or any other health professional involved in my care for this admission to hospital, to access health information about me that is relevant to my current treatment, which may be held by the hospital, other health professionals or other health organisations.

I understand and agree that photographic images may be made and stored confidentially as part of my health record for this episode of care.

I consent to being given blood or blood products if required ☐ Yes ☐ No

I understand that should a member of the healthcare team be directly exposed to my blood or other body fluids, I agree to blood samples being taken and tested for blood-borne diseases including Hepatitis and HIV. I understand I will be informed of the results if I request them, and any need for further medical referral.

Patient/Parent/Guardian Signature: Date:

CONSENT TO ANAESTHESIA

I agree to anaesthesia/sedation being given to myself (or my child).

I have received a satisfactory explanation of the reasons for, risks and likely outcomes of the anaesthesia and I have had the opportunity to ask questions and may seek more information at any time.

I acknowledge that I should not drive a motor vehicle, operate machinery or potentially dangerous appliances or make important decisions for 24 hours after having a general anaesthesia or sedation.

Patient/Parent/Guardian Signature: Date:

Anaesthetist/Surgeon Signature: Date: