MELBOURNE CENTRE FOR BARIATRIC SURGERY
EXPERIENCE . EXPERTISE . EMPATHY

Registration Form

Name_____ Date ____/____/_____

Personal Details

**Please note we may at times use your nominated email address for recalls and other communications of a medical nature*

Address: _____

_____

_____

DOB:____/____/_____ Age: _____

Married ☐ Single ☐

Divorced/Separated ☐ Partner/relationship ☐

Email*:_____

Home Phone: _____

Mobile Phone: _____

Work Phone: _____

Medicare Number: _____

Reference Number:_____Expiry Date:_/_/_____

Private Health Fund Yes No

Fund Name: _____

Number:_____

Reference Number: _____

Emergency Contact

Name: _____

Phone:_____

Relationship: _____

Referring Doctor

Usual GP Name: _____

_____

_____

Address: _____

_____

Phone: _____

Occupation: _____

Medical History

Do you have any of the following medical problems?

	Yes	No		Yes	No		Yes	No
Diabetes	☐	☐	Diabetes of pregnancy	☐	☐	Arthritis	☐	☐
On Insulin	☐	☐	Are you pregnant?	☐	☐	Back Problems	☐	☐
Heart Disease	☐	☐	High Blood Pressure	☐	☐	Other operations, admissions to hospital or psychological issues:		
Sleep Apnoea	☐	☐	High Cholesterol/Lipids	☐	☐			
Lung Disease eg asthma	☐	☐	Epilepsy	☐	☐			
Liver Disease eg hepatitis	☐	☐	Stroke/mini Stroke	☐	☐			
Gastric Band Surgery	☐	☐	Kidney Disease	☐	☐	Other Problems:		
Stomach Surgery	☐	☐	Pacemaker/ICD	☐	☐			
Reflux Disease	☐	☐	Thyroid Problems	☐	☐			
Stomach Ulcers	☐	☐	Clots in the leg/lung	☐	☐			
Smoker Current	☐	☐	Smoker in the past	☐	☐			
Infertility/PCOS	☐	☐	Depression/Anxiety	☐	☐			

Medication

Please list your current medication, including non-prescribed medication, doses are not required.

_____

_____

_____

Weight Loss Surgery Patients ONLY

Weight History

Please indicate your weight history by ticking the appropriate box:

	Below average	Average	Above average	Very heavy
Primary school	☐	☐	☐	☐
Secondary school	☐	☐	☐	☐
Commencing work	☐	☐	☐	☐
At time of marriage (if applicable)	☐	☐	☐	☐

Do you know anyone else who has had obesity surgery?	Yes	☐	No	☐	

Alcohol Intake — **Pleaseestimateyouralcoholintake perweek:** _____

STOP-BANG Sleep Apnoea Screening Survey:

Question	Circle YES or NO for each			
Do you SNORE loudly (loud enough to hear through closed door)?		YES		NO
Do you often feel TIRED, fatigued or sleepy during daytime?		YES		NO
Has anyone OBSERVED you stop breathing during your sleep?		YES		NO
Do you have or are you treated for HIGH BLOOD PRESSURE?		YES		NO
Is your BMI (Body Mass Index) over 35 kg/m^2		YES	UNSURE	NO
Is your AGE over 50?		YES		NO
Do you have a LARGE NECK SIZE? Examples: For male, is your shirt collar 43cm or larger? For female, shirt collar 41cm or large?		YES		NO
Is your gender MALE?		YES		NO
Office Use: TOTAL NUMBER OF "YES" ANSWERS:			OSA RISK:	

Exercise History

Are you currently exercising regularly?	Yes	No
What sort of Exercise do you enjoy doing?		
Are you able to run up a single flight of stairs without getting short of breath?	Yes	No

Preferred weight loss operation?

- ◯ Sleeve Gastrectomy
- ◯ Gastric Bypass
- ◯ Gastric Band
- ◯ Orbera Balloon
- ◯ Revision Surgery
- ◯ Loop Duodenal Switch (SIPS/SADI)

Where did you hear about us?

- ◯ Word of Mouth
- ◯ General Practitioner / Specialist
- ◯ Google Search Engine
- ◯ Social Media Platform
- ◯ Other:

Permission:

Please give permission for the information you provide in this questionnaire to be distributed for use by the surgeon, dietician, anaesthetist and physician during your weight loss surgery programme:

Signature: _____ Date: _____

PATIENT CONSENT FORM

We require your consent to collect personal information about you. Please read this information carefully and sign where indicated below.

The medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. This means we will use the information in the following ways:

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.
- Disclosure to other doctors in practice, locums and by Registrars attached to the practice for the purpose of patient care and teaching. Please let us know if you do not want your records accessed for these purposes, and we will note your record accordingly.
- Disclosure for research and quality assurance activities to improve individual and community health care and practice management.
- Bariatric Surgery Only ;
  - As a requirement for ongoing accreditation with ANZMOSS (Australia & New Zealand Metabolic & Obesity Surgery Society) it is necessary to contribute data to a national registry (de-identified data only) of Bariatric Surgery
  - All procedures may be recorded

I have read the information above and understand the reasons why my information must be collected.
I am also aware that this practice has a privacy policy on handling the patient information. I understand that I am not obliged to provide any information requested of me.

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.
I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.

I consent to the handling of my information by the practice for the purposes set out above, subject to any limitations on access or disclosure that I notify this practice of.

Signed_____(Patient) Date:____/____/____

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All Appointments & Correspondence to Box Hill Rooms