

ADRIAN POLGLASE

Professor of Surgery

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CABRINI MONASH UNIVERSITY DEPARTMENT OF SURGERY

COLORECTAL SURGERY
LAPAROSCOPIC SURGERY
COLONOSCOPY

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CONFIDENTIAL REGISTRATION FORM

SURNAME:TITLE Mr/Mrs/Miss/Ms/ Other

GIVEN NAMES

(as appears on Medicare Card)

HOME ADDRESS.....

..... POST CODE DATE OF BIRTH/...../.....

CONTACT NOS: (Home) (Business)..... (Mobile)

MEDICARE NO: **Number beside name on Medicare card** ()

Private Health Cover For A Private Hospital? YES /NO. NAME OF FUND FUND NO.

DO YOU RECEIVE A PENSION? YES / NO NUMBER:.....

DEPT VET AFFAIRS PATIENTS: CARD NO: CARD COLOUR:.....

1. NEXT OF KIN: RELATIONSHIP :.....

CONTACT NOS: (Home) (Business)..... (Mobile)

2. NEXT OF KIN RELATIONSHIP TEL NO:.....

(not living with you)

REFERRING DOCTOR: TEL NO:

ADDRESS:.....

GENERAL PRACTITIONER TEL NO:

(if same as referring doctor, write "as above")

ADDRESS:

DRUG OR MEDICATION ALLERGIES:

WHAT ARE YOUR CURRENT MEDICATIONS ?(including over the counter drugs, herbal or natural remedies or supplements of any kind)

PLEASE NOTE: If you are using over the counter drugs, herbal or natural remedies or supplements of any kind it is preferable to stop taking them as soon as possible for at least two weeks before an operation. If you are on blood thinning drugs, like but not limited to **Aspirin** (Astrix, Cartia, Disprin, Solprin), **Warfarin** (Coumadin, Marevan), **Clopidogrel** (Iscover, Plavix) then you must consult your doctor before the operation about what to do. If in doubt, ask for advice.

NO GAP AND KNOWN GAP ARRANGEMENTS: *This practice does participate in these arrangements and, when appropriate, endeavours to provide a written quotation for the surgical fee and any associated out of pocket expense (known gap) applicable, ONE WEEK prior to the proposed procedure.*

DATE FORM COMPLETED:/...../.....

LAST SEEN BY PROFESSOR POLGLASE ON:/...../.....