FORMS TO COMPLETE

Please complete and return this form to Ormiston Hospital 10 days prior to Surgery.

Ormiston Hospital, PO Box 38 921, Howick, Manukau 2145. A pre-paid envelope is enclosed.

PRIVACY

Ormiston Hospital respects your rights under the Health Information Privacy Code and the Privacy Act. All personal information and data collected is for the purpose of your treatment, to assist quality assurance and to fulfill legislative requirements. If you have any queries or concerns regarding this please contact the Hospital.

PATIENT ADMISSION FORM

DATE OF SURGERY:

☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Master ☐ Other.................. Gender: ☐ Male ☐ Female

Surname:.................... First Names:....................

Preferred Name:.................... Date of Birth: ...... / ...... / ...... (d m y) NHI:.................... (if known)

Residential Address:....................

Postal Address:.................... (if different from above) Postal Code:....................

Telephone: Home.................... Work.................... Mobile....................

NZ Resident: Yes ☐ No ☐ Ethnicity:.................... First Language:.................... Religion:....................

Interpreter: Yes ☐ No ☐ Language:.................... Name of Interpreter:....................

Contact Person:.................... Relationship to Patient:....................

Address:....................

Telephone: Home.................... Work.................... Mobile....................

Specialist:.................... Daystay ☐ Inpatient ☐

Proposed Surgery/Procedure:....................

General Practitioner:.................... Telephone:....................

GP Address:....................

Health Insurer:.................... Membership Number:....................

Approval Number:.................... **Please bring confirmation of Approval Number.**

ACC Number:....................

I ACKNOWLEDGE THAT:

I am responsible for any accounts relating to this admission.
I will settle the account prior to discharge unless other arrangements have been made.
I will be responsible for any debt collection costs incurred.

While every care will be taken with your essential items e.g. spectacles, watch etc, we request that you leave other valuables at home. Ormiston Hospital is unable to take responsibility for these items.

I give permission for Ormiston Hospital 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 Ormiston Hospital, other health professionals or other health organisations.

I AGREE THAT I HAVE READ AND UNDERSTOOD THE ABOVE STATEMENTS:

Patient's signature:.................... Date: ...... / ...... / ...... (d m y)

If not the patient, please state your relationship to the patient:....................

Ormiston Hospital

PATIENT HEALTH QUESTIONNAIRE

Surname: .... First Names: ....

Date of Birth: ..... / ..... / .....

All questions in this questionnaire are about the person being treated at the Hospital.

If you are filling this out for your child, only provide information relating to your child's health.

List procedures / operations / hospital admissions the patient has had (start with the most recent and work backwards).

Procedures/Operations/Admissions	Year	Hospital

HAVE YOU EVER HAD OR DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING?

Please tick a **Yes** or **No**. Circle a word where appropriate.

	Yes	No
Have you ever had any **allergic reaction** to medications, latex, iodine, plasters, food (particularly eggs) or any other substance?	☐	☐

If yes please **list your allergies and describe the reactions:** ....

	Yes	No
Do you carry a special health card or Medicalert bracelet	☐	☐
Have you had an anaesthetic before?	☐	☐
Have you or any other family member had any problems with an anaesthetic?	☐	☐
If yes, please explain:		
Do you have problems opening your mouth (E.g. previous jaw joint problems)?	☐	☐
Diabetes – Diet controlled/requiring tablets	☐	☐
Diabetes – Requiring Insulin, for how long:	☐	☐
High Blood Pressure / Palpitations	☐	☐
Angina / Heart Attack / Heart Failure / Chest Pain	☐	☐
Stroke / TIA (transient ischemic attack)	☐	☐
Epilepsy / Severe Headaches	☐	☐
Blackouts / Fainting	☐	☐
Asthma / Wheeziness	☐	☐
Emphysema / Bronchitis / Croup	☐	☐
Obstructive Sleep Apnoea	☐	☐
Rheumatic Fever / Heart Murmur	☐	☐
Tuberculosis	☐	☐
Heart Burn / Acid Reflux / Hiatus Hernia /	☐	☐
Indigestion / Stomach or Peptic Ulcer	☐	☐
Blood Clots in legs or lung	☐	☐
Bleeding Problems / Anaemia / Bruising	☐	☐
Family history of bleeding problems	☐	☐
Arthritis. If YES, which joints?	☐	☐
Any other illnesses or conditions?	☐	☐

If YES please specify: e.g. Kidney problems, Thyroid Disease, Muscular Dystrophy, Liver Problems, Malignant Hypothermia, Parkinson's Disease, Alzheimer's, Dementia, **other please state**

....

....

	Yes	No
Hepatitis A / B / C / Jaundice	☐	☐
Are you a Hepatitis carrier?	☐	☐
HIV / AIDS / risk of exposure to HIV	☐	☐
MRSA	☐	☐
In the last six months have you been a patient or employee in a hospital/s Name of Hospitals .... or been overseas .... Country	☐	☐
Have you had a "head cold", throat/chest infection or bronchitis in the past 4 weeks?	☐	☐
Have you had, or been in contact with anyone who has had, vomiting and/or diarrhoea in the past three days (and/or immediately before your admission)?	☐	☐
Boils, Skin or other Infections / Septicaemia. When?	☐	☐
Substance Dependency/High Use (e.g. drugs, alcohol)	☐	☐
Do you:		
Smoke / Used to Smoke? How many per day?	☐	☐
Drink alcohol daily? If YES, how much?	☐	☐
Wear Dentures / Partial Plate / have Capped or Loose Teeth	☐	☐
Wear Contact Lenses / Glasses / Hearing Aid	☐	☐
Have any Joint Implants / Pacemaker / Heart Valve / other Prosthetics / Implants / Piercings?	☐	☐
Believe you are pregnant? If YES state months	☐	☐
Suffer from motion sickness? mild / moderate / severe	☐	☐
Have difficulty climbing more than one flight of stairs? If YES, what restricts this activity?	☐	☐

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....

If you have answered yes to any of the above questions, please ensure you provide additional information on next page.

DO YOU TAKE MEDICATIONS OR REMEDIES FOR:

	Yes	No
Blood Thinning (e.g. warfarin, aspirin)	☐	☐
Heart Disease or High Blood Pressure	☐	☐
Diabetes or Epilepsy	☐	☐
Cortisone (steroids) or Anti-Inflammatories	☐	☐
Sleeplessness	☐	☐
Emotional Disorders or Psychiatric Illness	☐	☐
Oral Contraceptives	☐	☐

List ALL current medicines, drugs, tablets, inhalers, injections, herbal remedies, homeopathic, complementary medicines, vitamins and other supplements:

Medications / Remedies	Dose	Frequency

PLEASE BRING ALL THE ABOVE MEDICATIONS/REMEDIES IN THEIR ORIGINAL CONTAINERS TO THE HOSPITAL WITH YOU AND IDEALLY A PRINTOUT FROM YOUR PHARMACY THAT INCLUDES DOSAGE.

If you have answered yes to any of the above questions, please ensure you provide additional information below.

ADDITIONAL INFORMATION

IN PREPARATION FOR ADMISSION

Your Weight .... Your Height ....

To assist us fully to prepare for your hospital admission, and to ensure all of your needs are met during your stay and after discharge, please complete the following:

Your current residence:

☐ Private Home ☐ Apartment ☐ Rented Room ☐ Long Term Care Facility
☐ Boarding (Assisted living)

Do you live:

☐ Alone ☐ With Spouse ☐ Personal Care Attendant ☐ Group Setting

Does your home have:

☐ Separate Shower ☐ Shower Over Bath ☐ Multiple Stairs access Internal / External ☐ Ramps

Other mobility obstacles ....

Do you use:

☐ Cane ☐ Walking Frame ☐ Wheelchair

Other mobility aids ....

Current limitations or any difficulty with:

☐ Self Care ☐ Home Management (shopping, driving, chores) ☐ Existing Home Help
☐ Transferring from bed to chair ☐ Mobilising problems not associated with joint replacement

Other disabilities: ....

	Yes	No
Religious or Spiritual needs	☐	☐
Cultural or Family/Whanau needs	☐	☐
Interpreter Service Required	☐	☐

Language ....

Dietary Requirements: ☐ Standard Diabetic ☐ Vegetarian ☐ Gluten Free

Other ____________________

Is there anything that you would prefer to discuss on admission rather than document on this form?	☐	☐
Do you have anxieties, concerns, questions or additional matters you wish to discuss before your surgery with:	☐	☐

☐ Surgeon ☐ Anaesthetist ☐ Nurse ☐ Administration

Patient / Guardian signature: .... Date : ...... / ...... / ......
d m y

Please bring your Community Services card with you to the hospital. **There may be a charge for your prescription.**

ADDITIONAL INFORMATION

CONSENT FOR ANAESTHESIA

THIS IS TO BE COMPLETED BY THE ANAESTHETIST

Anaesthesia

I have had adequate opportunity to ask questions about the anaesthetic and the possible risks. I have received all the information I require. This was provided by Dr ....
(Anaesthetist to complete)

Type of anaesthetic: ☐ GA ☐ LA ☐ Sedation ☐ Regional ☐ Other: ....

Comments: ....

....

I AGREE to an anaesthetic being given. I acknowledge that I should not drive a motor vehicle, nor operate machinery or potentially dangerous appliances, drink alcoholic beverages or make important decisions for 24 hours after the operation having had a general anaesthetic. I agree that I have arranged to have an adult with me for a minimum of 24 hours post General Anaesthetic.

Specialist's Printed Name: ....

Specialist's Signature: ....

Date:..

Patient's Printed Name: ....

Patient's Signature: ....

Date: ....

If not the patient: Relationship:..

Printed Name:..

Signature:..

Date: ....

INVESTIGATION REQUIRED (for the following, please tick either: A = Prior to Admission, B = On Admission, C = Not Required)

Electrolytes	A B C	LFT's	A B C	Coag Screen	A B C	Ordered at Diagnostic Med Lab ☐
Routine Haematology	A B C	MSU	A B C	Group & Ab Screen	A B C	Ordered at Other Lab ☐
Urea & Creatinine	A B C	ECG	A B C	X match _____ units	A B C	

MRSA / ESBL Screen Yes ☐ No ☐

X Rays (state):

Other Tests (state):

REQUEST FOR TREATMENT

CONSENT TO SURGERY/PROCEDURE

THIS IS TO BE COMPLETED WITH SURGEON

I (full name) .... agree to the procedure / operation

....

Specified Side .... to be performed on me (or full name of child / relative) ....

....

I have had the opportunity to ask questions and have received all of the information I want. I understand that I am able to ask for more information if I wish and my consent may be withdrawn at any time. I confirm I have received a satisfactory explanation of the reasons for, risks and likely outcomes of the procedure / operation and the possibility and nature of further related treatment, including a return to theatre, should any complications arise.

Special additional risks and benefits explained to me (but not limited to) are:

....

....

....

....

....

Blood Products

Blood or Blood Products are NOT required for this procedure (please tick) ☐

I have had explained to me by.. the risks and benefits of the use of blood and blood products that may be administered during my operation or as part of my treatment. I have had the opportunity to discuss their use.

(Delete one of the following)

I AGREE to receiving blood/blood products if necessary

I DO NOT AGREE to receiving blood/blood products if necessary

I agree that, in the event of a health professional sustaining a sharps injury during my operation / procedure, a blood sample may be taken to test for blood-borne diseases including HIV, Hepatitis B & C. Counselling will be made available prior to the results being made available to me.

I wish to have any body parts / body substances returned to me Yes ☐ No ☐*
I understand that in certain circumstances this may not be possible. This has been explained to me.
*If no, I understand that all body parts not returned to me will be treated with respect and disposed of according to Ormiston Hospital policy

Specialist's Printed Name: ....

Specialist's Signature: ....

Date: ....

Patient's Printed Name: ....

Patient's Signature: ....

Date: ....

If not the patient: Relationship: ....

Printed Name:..

Signature:..

Date: ....