

FORMS TO FILL OUT

We need you to complete three pre-admission forms

We appreciate it can be a chore to complete forms, but to provide safe and personalised care we need current information from you.



One First, we need you to agree to receive treatment at our hospital.

AGREEMENT TO TREATMENT

Completed and signed by you and your admitting doctor.



Two Next, we need your personal and payment or insurance details.

PATIENT ADMISSION FORM

Completed and signed by you.



Three We also need to know your current state of health and your medical and surgical history, and we need an up-to-date list of the medicines you are currently taking. This information, along with your personal needs and preferences, will allow us to tailor your care throughout your hospital stay.

PATIENT HEALTH QUESTIONNAIRE

Completed by you.



We need to receive your completed forms before your admission

To enable us to properly prepare for your admission, your hospital needs to receive all three completed forms **at least one week prior** to your admission.

You can hand deliver, fax, scan and email, or post the forms*.

If you post the forms, please allow 1-2 extra weeks for delivery.

POST Use the pre-paid envelope enclosed

FAX 09 250 1159

EMAIL bookings@ormistonhospital.co.nz

DELIVER Ormiston Hospital, Level 3,
125 Ormiston Road, Flat Bush,
Auckland 2016

For enquiries please phone 09 250 1157

We protect your privacy

Any information and personal data gathered for the purpose of your visit to Ormiston Hospital is to assist in your treatment, for quality assurance activities, and to fulfil legislative requirements. Your rights provided in the Health Information Code and Privacy Act 1993* will be respected, including your right to access and correct any information held about you. If you have any concerns, please contact the Patient Services Manager†.

*More information can be found in the patient Information Compendium located in your hospital room or day-stay area, as well as online at www.privacy.org.nz

†The hospital Patient Services Manager is the hospital's Privacy Officer.



THIS SECTION IS COMPLETED BY THE ADMITTING DOCTOR

Surname (family name): _____

First name (s): _____

Patient's date of birth: ___/___/___ Diagnosis: _____

Procedure/operation/treatment description: _____

Operative side of body: Left / Right / Bilateral / Not applicable *(please circle)*

Sedation: Yes No Anaesthesia: Yes No Proposed anaesthesia: general / local / regional / spinal / epidural
(please circle)

Admission details

Admission date: ___/___/___ Admission time: _____ Procedure/Surgery date: ___/___/___
(If different to admission date)

Day stay unit Day inpatient Overnight inpatient Anticipated length of stay _____ hours / days / nights

Admitting doctor's instructions: _____

Admitting doctor's name: _____ Surgeon / Physician / General Practitioner

Admitting doctor's signature: _____ Date: ___/___/___
(please circle)

(where applicable please attach evidence of enduring power of attorney)

THIS SECTION IS COMPLETED BY THE PATIENT/GUARDIAN/ENDURING POWER OF ATTORNEY

I, _____ agree to have the procedure/operation/treatment described
(Patient's/Guardian's full name)

above performed on myself / my child _____ at _____
(please circle) (name of patient, if patient not signing form) (Hospital where you will be having your procedure/surgery)

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

I have had an opportunity to ask questions and understand that I may seek more information at any time and participate in decision making about my treatment.

I have been provided with sufficient information by my doctor in relation to the administration of blood components / blood products if necessary.

I give consent to the administration of blood or blood products if necessary: 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. These samples will be tested only to identify such transmissible diseases as are considered of significant risk e.g. Hepatitis and HIV. I understand I will be informed of the results if I request them, and any need for further medical referral. The results of these tests are confidential to me, the health professional(s) and the team member involved.

I give permission to Ormiston Hospital or any 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, Southern Cross, other health professionals or other health organisations.

Patient/Guardian signature: _____ Date: ___/___/___

If not patient, state relationship to patient: _____

(where applicable please attach evidence of enduring power of attorney)



PERSONAL AND ADMINISTRATION DETAILS

Surname (family name): _____ Mr Mrs Ms Miss Mstr Dr
First name(s): _____ Preferred name: _____
Date of birth: ___/___/___ Gender: Male Female NHI: _____
Residential address: _____
Postal address: _____
Email address: _____
Telephone: (Home) _____ (Business) _____ (Mobile) _____
New Zealand resident: Yes No
Ethnicity: European / Māori / Pacific Island / Asian / Middle Eastern / Latin American / African / Other _____
General Practitioner (Name): _____ Telephone: _____
Medical Centre: _____

NEXT OF KIN/CONTACT PERSON
Name: _____ Relationship to patient: _____
Address: _____
Telephone: (Home) _____ (Business) _____ (Mobile) _____

PAYMENT DETAILS

How will your procedure be paid for? Tick and complete as many as applies:
[] Health insurance (personal expenses such as telephone calls are excluded)
Name of Insurer: _____
Insurance Plan Name: _____ Membership No: _____
Have you obtained "prior approval" for payment? Yes [] No [] Approval No: _____
[] ACC (personal expenses such as telephone calls are excluded) [] DHB (some personal expenses are excluded)
[] Paid personally If you are paying for the procedure yourself, you may be asked to pay an estimated deposit 3-5 days before admission. The balance of your account must be settled on discharge.
I will pay my account by: EFTPOS [] Credit Card [] Debit Card [] Internet Banking [] Cheque []
For Internet Banking:
Payee: Ormiston Surgical and Endoscopy Bank a/c: 03-1529-0013375-00
Particulars: Patient Name Reference: Invoice number

AGREEMENT

I agree to settle my Hospital account in full at the time of my discharge when personally paying my account or where I do not have "prior approval" from my insurer. I understand I am responsible for any outstanding balance if my procedure is not fully covered by insurance, ACC or other contract.
I give permission for Ormiston Hospital to obtain any information relating to the approval/claim for this admission from the relevant funder/s, and I authorise that person or organisation to disclose such information to Ormiston Hospital. I accept that, in the event my Hospital account is not met, Ormiston Hospital reserves the right to add all costs of collection to this account.
I give permission to Ormiston Hospital or any 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 understand that other clinical team members such as student nurses and qualified medical trainees may have supervised involvement with my care and that I have the right to decline their presence or contribution to my care delivery.
I understand the admitting Surgeon, Anaesthetist and other Doctors or health professionals using Ormiston Hospital facilities are independent and not employees of Ormiston Hospital, with respect to both my treatment, care and account payment. I accept that this agreement is covered by New Zealand law. The details above have been completed by:
Name: _____ Date: ___/___/___
Signature: _____ If not the patient, state relationship to patient: _____



The hospital needs to receive all three forms at least one week prior to your admission. You can hand deliver, fax, scan and email, or post the forms. If you post the forms, please allow 1-2 extra weeks for delivery.

Please complete this questionnaire carefully as the information you supply helps us to provide you with the best and safest possible care during your stay at our hospital. The questionnaire has four sections:

- A Your general health
B In preparation for your hospital admission
C In preparation for your procedure
D Your current medicines

Form fields for Surname (family name), First name (s), Height, Weight, Surgeon, NHI (if known), and Occupation (optional). Includes a section for Hospital Administration only (Patient label).

All questions in this questionnaire are about the person being treated at the hospital (the patient). If you are filling this out for the patient, only provide information relating to the patient's health.

SECTION A YOUR GENERAL HEALTH

Table with 14 rows of medical procedure health alerts. Columns include Q., Yes, No, and If Yes. Questions range from difficulty climbing stairs to MedicAlert bracelet wearers.

SECTION A YOUR GENERAL HEALTH *(continued)*

A2. YOUR MEDICAL CONDITIONS

Do you currently have, or have you previously had, any of the following conditions?

If Yes, please circle any applicable options and provide comments in the box below.

Q.	Yes	No	
15	<input type="checkbox"/>	<input type="checkbox"/>	Breathing conditions: asthma wheeziness shortness of breath bronchitis croup emphysema COPD
16	<input type="checkbox"/>	<input type="checkbox"/>	Sleeping conditions: sleeplessness severe snoring obstructive sleep apnoea CPAP used
17	<input type="checkbox"/>	<input type="checkbox"/>	Heart conditions: palpitations irregular heart beat heart murmur angina heart attack chest pain congestive heart failure rheumatic fever
18	<input type="checkbox"/>	<input type="checkbox"/>	Stroke or Transient Ischaemic Attack (TIA)
19	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure or blood pressure controlled with medication
20	<input type="checkbox"/>	<input type="checkbox"/>	Blood clots: deep vein thrombosis (DVT) pulmonary embolus (PE)
21	<input type="checkbox"/>	<input type="checkbox"/>	Family history of blood clots
22	<input type="checkbox"/>	<input type="checkbox"/>	Blood or bleeding conditions: anaemia bruising
23	<input type="checkbox"/>	<input type="checkbox"/>	Family history of blood or bleeding conditions
24	<input type="checkbox"/>	<input type="checkbox"/>	Stomach and digestive conditions: indigestion heartburn acid reflux hiatus hernia peptic ulcer
25	<input type="checkbox"/>	<input type="checkbox"/>	Bowel conditions: irritable bowel syndrome constipation bowel disease
26	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease: jaundice hepatitis
27	<input type="checkbox"/>	<input type="checkbox"/>	Kidney conditions
28	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes: requiring insulin requiring tablets diet controlled
29	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid conditions
30	<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's disease
31	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy, seizures, blackouts or fainting
32	<input type="checkbox"/>	<input type="checkbox"/>	Migraines or severe headaches
33	<input type="checkbox"/>	<input type="checkbox"/>	Alzheimers or dementia
34	<input type="checkbox"/>	<input type="checkbox"/>	Mental function conditions: head injury concussion confusion or disorientation
35	<input type="checkbox"/>	<input type="checkbox"/>	Mental health conditions
36	<input type="checkbox"/>	<input type="checkbox"/>	Emotional conditions: anxiety phobia post traumatic stress disorder (PTSD)
37	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
38	<input type="checkbox"/>	<input type="checkbox"/>	Neck or back conditions
39	<input type="checkbox"/>	<input type="checkbox"/>	Gum or dental health conditions
40	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis (TB)
41	<input type="checkbox"/>	<input type="checkbox"/>	HIV or AIDS
42	<input type="checkbox"/>	<input type="checkbox"/>	Infection or treatment for resistant organisms: MRSA ESBL VRE OTHER
43	<input type="checkbox"/>	<input type="checkbox"/>	Cancer – <i>If Yes, please specify and provide details of any recent treatment in the comments box below</i>
44	<input type="checkbox"/>	<input type="checkbox"/>	Other condition(s) not listed above – <i>If Yes, please specify in the comments box below</i>

RE QUESTION	YOUR COMMENT
19	GP says my blood pressure is slightly high, but am not taking any medicine. --- Example ---

Need more space for your comments? Please continue on a separate sheet and attach it to this page.

Surname (family name)

First name (s)

Hospital Administration only
(Patient label)

SECTION B IN PREPARATION FOR YOUR HOSPITAL ADMISSION

B1. YOUR ALLERGIES, SENSITIVITIES, OR INTOLERANCES

Q. Yes No

45 Are you allergic to latex?

46 Do you have any **other allergies, sensitivities or intolerances**?

If Yes, please specify and describe the reaction using the box below

	Item	Reaction
Skin-related	Plasters --- Example ---	Rash --- Example ---
Medicine-related		
Food-related		
Other		

B2. YOUR NEEDS AND PREFERENCES

Please answer these questions to help us to tailor how we care for you.

If you answer Yes to any of these questions, we may contact you to discuss your specific needs.

Q. Yes No

If Yes

47 Do you have a disability? *Specify:*

48 Do you have difficulty understanding English? *Your preferred language:*

49 Do you have any religious or spiritual needs you would like us to know about? *Specify:*

50 Do you have any cultural or family needs you would like us to know about? *Specify:*

51 Do you have any other special needs you would like us to know about? *Specify:*

52 If your procedure requires the removal of body parts, would you like them returned to you if this is possible?

53 Do you have any dietary requirements?
 vegetarian vegan diabetic
 gluten free halal dairy free
 other _____

54 Do you have any specific food dislikes? *Specify:*
For allergies or intolerances, refer to question 46

SECTION C IN PREPARATION FOR YOUR PROCEDURE

B1. MEDICAL PROCEDURE HISTORY

Q.	Yes	No																
55	<input type="checkbox"/>	<input type="checkbox"/>	Have you previously had any procedures / operations or other hospital admissions? <i>– If Yes, please outline your previous admissions in the table below. If you need more space, please continue on a separate sheet and attach it to this page</i>															
			<table border="1"> <thead> <tr> <th>Procedure or event</th> <th>Year</th> <th>Hospital</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>	Procedure or event	Year	Hospital												
Procedure or event	Year	Hospital																

C2. ANAESTHESIA CONSIDERATIONS

Q.	Yes	No		If Yes
56	<input type="checkbox"/>	<input type="checkbox"/>	Have you had an anaesthetic before?	<input type="checkbox"/> general <input type="checkbox"/> spinal <input type="checkbox"/> epidural <input type="checkbox"/> unsure
57	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any of these dental features ?	<input type="checkbox"/> upper denture <input type="checkbox"/> lower denture <input type="checkbox"/> crown(s) / cap(s) <input type="checkbox"/> partial plate <input type="checkbox"/> loose or chipped teeth
58	<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcohol ?	How much? _____

C3. PERSONAL ITEMS

Do you use any of these personal items?

Q.	Yes	No		If Yes, use this space to provide details, if needed
59	<input type="checkbox"/>	<input type="checkbox"/>	Mobility aids, such as a walking stick or cane	
60	<input type="checkbox"/>	<input type="checkbox"/>	Glasses or contact lenses	
61	<input type="checkbox"/>	<input type="checkbox"/>	Hearing aids	
62	<input type="checkbox"/>	<input type="checkbox"/>	Earrings or other piercing jewellery	

C4. BLOOD CLOT AND INFECTION CONSIDERATIONS

Q.	Yes	No	
63	<input type="checkbox"/>	<input type="checkbox"/>	Have you completed the pre-admission risk assessment in the Blood Clots and YOU brochure?
64	<input type="checkbox"/>	<input type="checkbox"/>	Have you recently been on a long distance flight ?
65	<input type="checkbox"/>	<input type="checkbox"/>	In the past 3 days, have you had, or been in contact with anyone who has had, vomiting or diarrhoea ?
66	<input type="checkbox"/>	<input type="checkbox"/>	In the past 7 days, have you experienced flu-like symptoms , or been in contact with anyone diagnosed with influenza ?
67	<input type="checkbox"/>	<input type="checkbox"/>	In the past 4 weeks, have you had a head cold, throat or chest infection, or bronchitis ?
68	<input type="checkbox"/>	<input type="checkbox"/>	In the past 12 months, have you travelled overseas , or been a patient or employee in a hospital or rest home in New Zealand or overseas? <i>– If Yes, please specify</i> _____
69	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any boils, cuts, sores, scratches or other skin or urine infections ?

C5. OTHER CONCERNS

Q.	Yes	No	
70	<input type="checkbox"/>	<input type="checkbox"/>	Is there anything we need to know that you prefer not to write on this questionnaire? <i>– If Yes, please discuss with your nurse or medical specialist when you arrive at the hospital</i>
71	<input type="checkbox"/>	<input type="checkbox"/>	Do you have anxieties, concerns, or questions you wish to discuss before your procedure? <i>– If Yes, who would you like to speak with?</i>

your surgeon your anaesthetist
 a nurse one of our admin staff

