Southern Cross

Ormiston Hospital & Healthcare

Agreement to Treatment

THIS SECTION IS COMPLETED BY THE ADMITTING DOCTOR

First Name : _____ Last Name : _____

Date Of Birth : ____ / ____ / ____ Diagnosis : _____

Procedure/operation/treatment description : _____

_____

Risks discussed : _____

_____

Operative side of body: Left ☐ Right ☐ Bilateral ☐ Not applicable ☐

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

Admission details

Admission date: _____ Admission time: _____ Procedure/Surgery 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 (please circle)

Admitting doctor's signature : _____ Date : _____

(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 listed above 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 authorise Ormiston Surgical and Endoscopy Ltd (as well as any healthcare professionals involved in my care), to access relevant health information, related to my current treatment and any other necessary communications. This may include records or communications held by Ormiston, Southern Cross Healthcare, other healthcare professionals, or other healthcare organisations.

I consent to the use of photography or filming for teaching and training purposes ☐

Patient/Guardian signature: _____ Date: _____

If not patient, state relationship to patient: _____

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

Anaesthesia
Plan and Consent

Hospital Administration only
(Patient label)

THIS SECTION IS COMPLETED BY THE ANAESTHETIST

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

Risk discussion

Sore Throat ☐ Nausea/Vomiting ☐ Dental Damage ☐ Allergic Reaction ☐ Itch ☐ Blood Clots ☐

Block Failure ☐ Nerve Damage ☐ Headache ☐ Hypotension ☐ Rare Serious Events ☐ Pain ☐ Bleeding ☐

Other : _____

_____

Pain Relief Plan

Oral ☐ Intravenous ☐ PCA ☐ Epidural ☐ Spinal ☐ Wound ☐ Catheter ☐ Other ☐

Discussion notes : _____

_____

Anaesthetist Statement

I have discussed the proposed anaesthetic plan and possible alternatives with the:

Patient ☐ Parent/Guardian ☐ Spouse/Partner ☐ Next-of-Kin ☐ POA ☐

Anaesthetist name : _____ **Date :** _____

Anaesthetist signature : _____

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

I, _____ agree to anaesthesia/sedation being given to
(Patient's/Guardian's full name)

myself / my child _____
(please circle) (name of patient, if patient not signing form)

I confirm that 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 understand I may seek more information at any time.

I understand the proposed anaesthesia may change as deemed necessary by the Anaesthetist.

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 had the anaesthesia.

Patient/Guardian signature: _____ **Date:** _____

If not patient, state relationship to patient: _____

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

Patient Admission Form

PERSONAL AND ADMINISTRATION DETAILS

Surname (family name): _____ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Mstr ☐ Dr ☐

First name(s): _____ **Preferred name:** _____

Date of birth: _____ **NHI:** _____

Sex at birth: Male ☐ Female ☐ **Gender:** Male ☐ Female ☐ Gender diverse ☐ Non-binary ☐ Other ☐

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 Number: _____

Have you obtained "prior approval" for payment? YES ☐ NO ☐ Approval Number: _____

☐ **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 ☐ Credit Card Authorisation ☐

For Internet Banking:
Payee: Ormiston Surgical and Endoscopy | **Particulars**: Patient Name | **Bank a/c**: 02-0191-0522222-00 | **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. Estimates provided by surgical rooms are subject to change with potential cost variations relating to theatre time or resources.
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 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 payments.
I accept that this agreement is covered by New Zealand law. The details above have been completed by:

Name: _____ **Date:** _____

Signature: _____ **If not patient, state relationship to patient:** _____

Southern Cross

Ormiston Hospital & Healthcare

Patient Health Questionnaire

The hospital needs to receive all three forms at least one week prior to your admission. You can hand deliver, fax, scan and email the forms.

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

Surname (family name) _____

First name (s) _____

Hospital Administration only
(Patient label)

Height _____ metres _____

Weight _____ kilograms _____ Surgeon _____

Occupation (optional) _____ NHI (if known) _____

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

A1: MEDICAL PROCEDURE HEALTH ALERTS

Do any of the following apply to you?

Yes	No	Question	If Yes
☐	☐	01. Difficulty climbing more than a flight of stairs	What restricts this activity? ☐ mild | ☐ moderate | ☐ severe
☐	☐	02. Motion Sickness	
☐	☐	03. Jaw problems (difficulty opening mouth)	Specify:
☐	☐	04. Problems with a previous anaesthetic:	Specify:
☐	☐	05. Family history of problems with an anaesthetic	Specify:
☐	☐	06. Pacemaker or heart valve replacement	Specify:
☐	☐	07. Joint implants	Specify:
☐	☐	08. Other implants or prostheses	Specify:
☐	☐	09. Substance use or dependency	Specify:
☐	☐	10. Former smoker	When did you quit?
☐	☐	11. Currently on smoking cessation treatment	Specify:
☐	☐	12. Current smoker	How many per day?
☐	☐	13. Pregnant or possibly pregnant	Approximate due date:
☐	☐	14. MedicAlert bracelet or necklace wearer	Specify:

Hospital Administration only
(Patient label)

Southern Cross
Ormiston
Hospital & Healthcare

SECTION A : YOUR GENERAL HEALTH (continued)

A2: YOUR MEDICAL CONDITONS

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.

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

YOUR COMMENTS

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

Yes	No	Question
☐	☐	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		
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.

Yes	No	Question	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 have any specific food dislikes For allergies or intolerances, refer to question 46	Specify:

SECTION C : IN PREPARATION FOR YOUR PROCEDURE

C1: MEDICAL PROCEDURE HISTORY

Yes No Question

☐ ☐ 55. Have you previously had any procedures/operations or other hospital admissions?
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.

PROCEDURE/EVENT	YEAR	HOSPITAL

C2: ANAESTHESIA CONSIDERATIONS

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

C3: PERSONAL ITEMS

Do you use any of these personal items?

Yes	No	Question	If Yes, use this space to provide details, if needed
☐	☐	59. Mobility aids, such as a walking stick or cane	
☐	☐	60. Glasses or contact lenses	
☐	☐	61. Hearing aids	
☐	☐	62. Earrings or other piercing jewellery	

C4: BLOOD CLOT AND INFECTION CONSIDERATIONS

Yes No Question

☐ ☐ 63. Have you completed the pre-admission risk assessment in the Blood Clots & YOU brochure?

☐ ☐ 64. Have you recently been on a long distance flight?

☐ ☐ 65. In the past 3 days, have you had, or been in contact with anyone who has had, vomiting or diarrhoea?

☐ ☐ 66. In the past 7 days, have you experienced flu-like symptoms, or been in contact with anyone diagnosed with influenza/Covid-19?

☐ ☐ 67. In the past 4 weeks, have you had a head cold, throat or chest infection, or bronchitis?

☐ ☐ 68. 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? If Yes, please specify

☐ ☐ 69a Do you have any boils, cuts, sores, scratches or other skin or urine infections?

☐ ☐ 69b Have you had previous issues with healing or skin infections?

Surname (family name)

First name (s)

Hospital Administration only
(Patient label)

SECTION D: YOUR CURRENT MEDICINES

For your safety, it is extremely important that your doctors and nurses know precisely which medicines you are currently using. Important instructions.
1. List below all medicines you currently use, and bring them with you to the hospital in their original containers
2. To ensure you are clear what to include, please use the MEDICINE REMINDERS table
3. If you have a medication card or printout from your GP or pharmacist, please bring it with you to the hospital, as well as completing the list below.

MEDICINE REMINDERS Which of the examples below apply to you?		
There are many types of medicine	Medicines come in many forms	Medicines are taken for many common conditions
prescription medicines, herbal medicines, natural medicines, homeopathic remedies, over-the-counter medicines, vitamins, supplements, contraceptives, steroids	tablets, capsules, inhalers, drops, syrups, patches, suppositories, creams, injections, other liquids	heart disease, high blood pressure, blood thinning, emotional conditions, infections, diabetes, sleeplessness, epilepsy

D1. YOUR CURRENT MEDICINES			HOSPITAL USE ONLY					
Patient to complete - list all medicines you currently use.			Reconciled: Yes (Y) | No (N) | Not Available (NA)				Comment if No	On Admission: Date/Time last taken
Name of Medicine	Strength	How much you use, and when	Medicine Container	Medication Card	Patient or Whānau/family	Other (state) eg. 'phoned GP'		
Example - Paracetamol	500mg	2 capsules every 6 hours	-	-	-	-	-	-