



Forms to fill in

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.

- 01.** First, we need you to agree to receive treatment at our hospital.
AGREEMENT TO TREATMENT
Completed and signed by you and your admitting doctor.
- 02.** Next, we need your personal and payment or insurance details.
PATIENT ADMISSION FORM
Completed and signed by you.
- 03.** 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 or scan and email the completed forms back to us.

EMAIL admissions@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 fulfill legislative requirements. Your rights provided in the Health Information Privacy Code and Privacy Act 2020* will be respected, including your right to access and correct any information help 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 or www.hdc.org.nz

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

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

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

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

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: 02-0191-0522222-000 | 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 completely by:

Name: _____ Date: _____

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

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
<input type="checkbox"/>	<input type="checkbox"/>	01. Difficulty climbing more than a flight of stairs	What restricts this activity? _____
<input type="checkbox"/>	<input type="checkbox"/>	02. Motion Sickness	mild <input type="checkbox"/> moderate <input type="checkbox"/> severe <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	03. Jaw problems (difficulty opening mouth)	Specify: _____
<input type="checkbox"/>	<input type="checkbox"/>	04. Problems with a previous anaesthetic:	Specify: _____
<input type="checkbox"/>	<input type="checkbox"/>	05. Family history of problems with an anaesthetic	Specify: _____
<input type="checkbox"/>	<input type="checkbox"/>	06. Pacemaker or heart valve replacement	Specify: _____
<input type="checkbox"/>	<input type="checkbox"/>	07. Joint implants	Specify: _____
<input type="checkbox"/>	<input type="checkbox"/>	08. Other implants or prostheses	Specify: _____
<input type="checkbox"/>	<input type="checkbox"/>	09. Substance use or dependency	Specify: _____
<input type="checkbox"/>	<input type="checkbox"/>	10. Former smoker	When did you quit? _____
<input type="checkbox"/>	<input type="checkbox"/>	11. Currently on smoking cessation treatment	Specify: _____
<input type="checkbox"/>	<input type="checkbox"/>	12. Current smoker	How many per day? _____
<input type="checkbox"/>	<input type="checkbox"/>	13. Pregnant or possibly pregnant	Approximate due date: _____
<input type="checkbox"/>	<input type="checkbox"/>	14. MedicAlert bracelet or necklace wearer	Specify: _____

Hospital Administration only
(Patient label)

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, specify
<input type="checkbox"/>	<input type="checkbox"/>	15. Breathing conditions: asthma wheeziness shortness of breath bronchitis croup emphysema COPD	_____
<input type="checkbox"/>	<input type="checkbox"/>	16. Sleeping conditions: sleeplessness severe snoring obstructive sleep apnoea CPAP used	_____
<input type="checkbox"/>	<input type="checkbox"/>	17. Heart conditions: palpitations irregular heart beat heart murmur angina heart attack chest paincongestive heart failure rheumatic fever	_____
<input type="checkbox"/>	<input type="checkbox"/>	18. Stroke or Transient Ischaemic Attack (TIA)	_____
<input type="checkbox"/>	<input type="checkbox"/>	19. High blood pressure or blood pressure controlled with medication	_____
<input type="checkbox"/>	<input type="checkbox"/>	20. Blood clots: deep vein thrombosis (DVT) pulmonary embolus (PE)	_____
<input type="checkbox"/>	<input type="checkbox"/>	21. Family history of blood clots	_____
<input type="checkbox"/>	<input type="checkbox"/>	22. Blood or bleeding conditions: anaemia bruising	_____
<input type="checkbox"/>	<input type="checkbox"/>	23. Family history of blood or bleeding conditions	_____
<input type="checkbox"/>	<input type="checkbox"/>	24. Stomach and digestive conditions: indigestion heartburn acid reflux hiatus hernia peptic ulcer	_____
<input type="checkbox"/>	<input type="checkbox"/>	25. Bowel conditions: irritable bowel syndrome constipation bowel disease	_____
<input type="checkbox"/>	<input type="checkbox"/>	26. Liver disease: jaundice hepatitis	_____
<input type="checkbox"/>	<input type="checkbox"/>	27. Kidney conditions	_____
<input type="checkbox"/>	<input type="checkbox"/>	28. Diabetes: requiring insulin requiring tablets diet controlled	_____
<input type="checkbox"/>	<input type="checkbox"/>	29. Thyroid conditions	_____
<input type="checkbox"/>	<input type="checkbox"/>	30. Parkinson's disease	_____
<input type="checkbox"/>	<input type="checkbox"/>	31. Epilepsy, seizures, blackouts or fainting	_____
<input type="checkbox"/>	<input type="checkbox"/>	32. Migraines or severe headaches	_____
<input type="checkbox"/>	<input type="checkbox"/>	33. Alzheimers or dementia	_____
<input type="checkbox"/>	<input type="checkbox"/>	34. Mental function conditions: head injury concussion confusion or disorientation	_____
<input type="checkbox"/>	<input type="checkbox"/>	35. Mental health conditions	_____
<input type="checkbox"/>	<input type="checkbox"/>	36. Emotional conditions: anxiety phobia post traumatic stress disorder (PTSD)	_____
<input type="checkbox"/>	<input type="checkbox"/>	37. Arthritis	_____
<input type="checkbox"/>	<input type="checkbox"/>	38. Neck or back conditions	_____
<input type="checkbox"/>	<input type="checkbox"/>	39. Gum or dental health conditions	_____
<input type="checkbox"/>	<input type="checkbox"/>	40. Tuberculosis (TB)	_____
<input type="checkbox"/>	<input type="checkbox"/>	41. HIV or AIDS	_____
<input type="checkbox"/>	<input type="checkbox"/>	42. Infection or treatment for resistant organisms: MRSA ESBL VRE OTHER	_____
<input type="checkbox"/>	<input type="checkbox"/>	43. Cancer: If Yes, please specify and provide details of any recent treatment below	_____
<input type="checkbox"/>	<input type="checkbox"/>	44. Other condition(s) not listed above: Other condition(s) not listed above – If Yes, please specify 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

47. Do you have a disability?

48. Do you have difficulty understanding English?

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

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

51. Do you have any other special needs you would like us to know about?

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

If Yes

Specify: _____

Your preferred language: _____

Specify: _____

Specify: _____

Specify: _____

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

56. Have you had anaesthetic before?
57. Do you have any of these dental features?
58. Do you drink alcohol?

If Yes

- general spinal epidural unsure
- upper denture lower denture crown(s) cap(s)
- partial plate loose or chipped teeth
- How much? _____

C3: PERSONAL ITEMS

Do you use any of these personal items?

Yes No Question

59. Mobility aids, such as a walking stick or cane
60. Glasses or contact lenses
61. Hearing aids
62. Earrings or other piercing jewellery

If Yes, use this space to provide details, if needed

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 where
- 69a Do you have any boils, cuts, sores, scratches or other skin or urine infections?
Please specify
- 69b Have you had previous issues with healing or skin infections? Please specify

