ANGLESEA HOSPITAL PATIENT ADMISSION FORM

Admission Date: | Admission Time:

Nil per Mouth:
FOOD AND FLUIDS | ARRIVAL TIME:
OFFICE USE ONLY

Please complete and return this form one week prior to your booked admission to:

Anglesea Hospital
South Bloc, Knox Street, Hamilton 3204
PO Box 9077, Waikato Mail Centre, Hamilton 3240
Phone: (07) 957 4915
Email: reception@angleseahospital.co.nz

The information requested in this form will help us assess your needs and plan for your care at Anglesea Hospital.

Please answer all the questions on each page as accurately as possible, even if you think they are irrelevant.

Please bring any relevant X-rays/CT/MRI scans (CD discs) with you, any mobility aids, CPAP machines etc. to the hospital.

If you develop any coughs, colds, infections or wounds before your admission contact the hospital on 07 957 4915.

We look forward to helping you prepare for your operation/procedure

PERSONAL AND ADMINISTRATION DETAILS

Surname: ..... Mr / Mrs / Ms / Miss / Master / Dr

First name(s) ..... Preferred name: .....

Date of Birth: ...../...../..... Age..... Gender: M / F

Residential address .....

Postal address: .....

Email address: ..... Occupation:.....

Telephone (Mobile) ..... (Work) ..... (Home) .....

General Practitioner: .....

Medical Centre: ..... Ethnicity: .....

Emergency Contact Name ..... Relationship .....
This is the person we will contact in case of an emergency. Please make sure this person is aware you are having this operation.

Address .....

Telephone (Mobile) ..... (Work) ..... (Home) .....

PAYMENT DETAILS

Your account will be emailed to you – unless otherwise requested

How will your procedure be paid for? Tick and complete as many as applies:

☐ **Health Insurance** Name of Insurer: .....

Have you obtained "prior approval" for payment? ☐ Yes ☐ No Approval No:.....
Please provide your credit card details below to cover any shortfall on your insurance.

☐ **ACC** Approval No: .....

☐ **Self-Funding** If you are paying for the procedure yourself, please provide credit card details.

Card Type: Mastercard Visa AMEX

Credit Card Number ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Expiry Date ...../.....

Name on Credit Card..... Signature .....

I understand that signing this credit card authority authorises Anglesea Hospital to debit my credit card with all amounts due and owing to Anglesea Hospital in relation to my admission and treatment at Anglesea Hospital.

If paying by Eftpos or Internet Banking you must contact us prior to surgery to discuss prepayment options.

For Internet banking:
Payee: Anglesea Hospital
Particulars: Patient Name
Bank a/c: 02-0316-0223892-00
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.

I give permission for Anglesea 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 Anglesea Hospital. I accept that, in the event my hospital account is not met, Anglesea Hospital reserves the right to add all costs of collection to this account.

I give permission to Anglesea 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 Anglesea 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 a right to decline their presence or contribution to my care delivery.

I understand the admitting Surgeon, Anaesthetist and other Doctors or health professionals using Anglesea Hospital facilities are independent and not employees of Anglesea Hospital, with respect to both my treatment, care and account payment.

I accept that this agreement is covered by New Zealand law. The details on this form have been completed by:

Name:..... Date: .....

Signature: .....

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

Patient label

PATIENT HEALTH QUESTIONNAIRE

PREVIOUS HOSPITAL ADMISSIONS

Please list previous hospital admissions including year and hospital (if known) *Attach separate paper if required*

Reason for admission	Date	Hospital

ALLERGIES

Have you ever had a reaction / allergy to any medications, tablets, plasters, food, latex/rubber or any other substance?
If so, please list

Substance	Type of Reaction	Substance	Type of Reaction

MEDICATIONS

Please bring with you all medications / remedies / supplements in their original containers to the hospital and a current printout from your GP or pharmacy that includes dosage regime. If your medications are in a blister pack please bring the entire pack. List your current medications below including tablets, inhalers, herbal remedies, vitamins and other supplements.

Medication	Dose	Time taken

Do you take medications or remedies for:			Do you take:		
Blood thinning (e.g. Warfarin, Aspirin, Clopidogrel)	YES	NO	Cortisone (Steroids) or Anti-inflammatories	YES	NO
Heart Disease or High Blood Pressure	YES	NO			
Diabetes or Epilepsy	YES	NO	Oral Contraception or HRT	YES	NO
Sleeplessness	YES	NO			
Emotional Conditions	YES	NO			

GENERAL HEALTH

Do you suffer from, or have you ever suffered from, the following? *Circle applicable*

Chest pains / tightness or Angina	YES	NO	Shortness of breath	YES	NO
Rheumatic fever	YES	NO	Asthma	YES	NO
Heart Attack	YES	NO	Emphysema or Bronchitis	YES	NO
Palpitations	YES	NO	Tuberculosis	YES	NO
Heart Murmur	YES	NO	Obstructive Sleep Apnoea	YES	NO
High Blood Pressure	YES	NO	Persistent Cough	YES	NO
Artificial Heart valve or Pacemaker	YES	NO	Kidney Disease	YES	NO
Hiatus Hernia/ Heartburn / Indigestion	YES	NO	Thyroid Disease	YES	NO
Rheumatoid Arthritis	YES	NO	Prostate Conditions	YES	NO
HIV / Aids	YES	NO	Previous DVT or Lung Embolus	YES	NO
Jaundice or Hepatitis	YES	NO	Stroke or Seizures	YES	NO
Paralysis / Impaired sensation	YES	NO	Pressure areas / skin ulcers	YES	NO
Do you have wounds/broken skin at present	YES	NO	Anxiety / Depression	YES	NO
Thin/fragile skin that bruises/breaks easily	YES	NO		YES	NO

Diabetes ■ Yes ■ No	Your Weight: kg
■ Insulin ■ Oral Medication ■ Diet Controlled	Your Height: metres

If you have answered yes to any of the above, please give further details below
Attach separate paper if required

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Do you suffer from any other conditions, not covered elsewhere, that you feel we should know about?
If so, please specify ■ Y ■ N

.....

.....

Do you have any concerns or questions about your anaesthetic? *If so, please specify* ■ Y ■ N

.....

.....

Have you been in any other hospital / rest home as a patient or staff member in the last 6 months?
■ Y ■ N

Have you ever been told you have MRSA, or other antibiotic resistant organism?
If so please outline ■ Y ■ N

.....

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Have you been in contact with measles, mumps or chickenpox in the last 2 weeks? ■ Y ■ N

Do you smoke?	YES	NO	How many per day?
Do you drink alcohol?	YES	NO	How many alcoholic drinks per day?
Do you use recreational drugs?	YES	NO	What and how often?

Are there any major illnesses to your knowledge, within your blood relatives eg. Diabetes, Blood clots, muscular dystrophy, malignant hyperthermia etc? *If so, please specify* ■ Y ■ N

.....

.....

Have you or any of your family ever had problems with an anaesthetic? *If so, please outline* ■ Y ■ N

.....

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What physical activity do you take part in on a regular basis?

■ Walking ■ Running ■ Golf ■ Tennis ■ Other .....

How many flights of stairs can you climb without getting short of breath? ■ 0 ■ 1 ■ 2 ■ 3 or more

My activity is limited by: ■ Chest pain ■ Joint pain ■ SOB ■ Other ..... ■ N/A

DO YOU WEAR: *(tick appropriate boxes)*

■ Dentures ■ Partial Plate ■ Capped teeth ■ Hearing Aids ■ Contact Lenses ■ Glasses

DO YOU HAVE: *(tick appropriate boxes)*

■ Joint Implants ■ Pacemaker ■ Heart valve ■ Implants ■ Piercings ■ Other Prosthesis

DO YOU SUFFER FROM MOTION SICKNESS: ■ Yes ■ No ■ Mild ■ Moderate ■ Severe

DIETARY REQUIREMENTS: ■ Diabetic ■ Vegetarian ■ Gluten free ■ Dairy free ■ Other.....

Do you have any physical, emotional, spiritual, cultural or communication needs?

.....

WOMEN ONLY Are you, or could you be pregnant? ■ Yes ■ No

The details above have been completed by: - PLEASE SIGN BELOW

■ Patient ■ Guardian ■ Relative ■ or other? .....

Signed: ..... Date: .....

To be completed on admission:

Has there been any change in your health since completing the questionnaire? ■ Yes ■ No

If yes please outline changes below:

Patient label

AGREEMENT TO TREATMENT

THIS SECTION IS COMPLETED BY THE ADMITTING DOCTOR

Surname (family name):

First name(s):

Procedure / Operation / Treatment description:

.....

.....

OPERATIVE SIDE OF BODY: ■ Left ■ Right ■ Bilateral ■ Not applicable

SEDATION / ANAESTHESIA / PROPOSED ANAESTHESIA: General / Local / Regional / Spinal / Epidural *(please circle)*

RISKS DISCUSSED: .....

.....

.....

SURGEONS NAME:

SURGEONS SIGNATURE: DATE:

THIS SECTION TO BE COMPLETED BY THE PATIENT (OR PARENT / GUARDIAN)

I ..... request and agree to undergo the operation / procedure / treatment described above be performed on myself / my child *(delete one)*.

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 should any complications arise including a return to theatre.

I have been informed of both benefits and risks including possible rare but serious risks. I understand that if found essential, further or alternative operative / procedural measures may be undertaken during the course of the operation / procedure.

I have had the opportunity to ask questions and may seek more information at any time.

I give permission for Anglesea 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 the hospital, other health professionals or other health organisations.

I understand and agree that photographic images may be made and stored confidentially as part of my health record for this episode of care.

I consent to being given blood or blood products if required ■ 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 for blood-borne diseases including Hepatitis and HIV. I understand I will be informed of the results if I request them, and any need for further medical referral.

I wish to have my surgically removed body parts returned to me
(I understand in some circumstances this may not be possible) ■ Yes ■ No

Patient / Parent / Guardian Signature Date

CONSENT TO ANAESTHESIA

I agree to anaesthesia / sedation being given to myself (or my child).

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 may seek more information at any time.

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 a general anaesthesia or sedation.

Patient / Parent / Guardian Signature Date

Anaesthetist / Surgeon Signature Date