CONFIDENTIAL ADMISSION FORM

ST GEORGE'S HOSPITAL
A TRADITION OF EXCELLENCE

○ **HOSPITAL ENTRANCE -** Heaton Street

PLEASE COMPLETE & RETURN THIS FORM TO THE HOSPITAL 5 DAYS PRIOR TO ADMISSION (WHERE POSSIBLE)

FOR OFFICE USE ONLY

ADMISSION DATE _____

ADMISSION TIME _____

NHI _____

ACC ○ YES ○ NO

Personal details - (to be filled in by patient or parent/guardian) No labels please

Surname: (Family name) _____ Mr/Mrs/Miss/Ms/Mstr/Other: _____

Given names: _____ Preferred name: _____

Previous / Maiden names: _____ Occupation: _____

Address: _____

City: _____ **Postcode:** _____

Mailing address: (if different from above) _____ **Postcode:** _____

Email address: _____

Date of birth: _____ ○ Female ○ Male

You can contact me via (please tick applicable options) ○ Cellphone ○ Work phone ○ Home phone ○ Email ○ Post

Phone: _____ Work: _____ Cell/Alt: _____

Surgeon / Clinician: _____ GP: _____

Our hospital chaplain is available to all. Please indicate if you would like a visit: ○ Yes ○ No Religion (optional) _____

THIS INFORMATION IS REQUIRED FOR STATISTICAL PURPOSES

Country of birth: _____ New Zealand residency status: ○ Yes ○ No

First language: *(if not English)* _____ Do you require a translator: *(enquire re fee)* ○ Yes ○ No

Which ethnic group do you belong to? Mark the space or spaces that apply to you.

○ New Zealand European ○ Maori ○ Samoan ○ Cook Island Maori ○ Tongan ○ Niuean ○ Chinese ○ Indian

Other *(such as Dutch, Japanese,Tokelauan)* - Please state: _____

Important information for your admission

Contact name: _____ Relationship: _____

Would you like the surgeon to contact this person after the surgery if possible? Please note not all surgeons offer this service ○ Yes ○ No

Address: _____

Telephone no. home: _____ Work/mobile: _____

Alternative contact name: _____ Relationship: _____

Telephone no. home: _____ Work/mobile: _____

The hospital will forward all phone calls for you to your bedside phone. If you do not wish this to happen please contact the hospital to organise alternative arrangements.

Have you undertaken any overseas travel in the last 6 months? ○ Yes ○ No If so, where? _____

Have you been admitted to any hospital in the last 6 months? ○ Yes ○ No

If yes, where? _____ Under what name: _____

Have you ever been treated for MRSA? ○ Yes ○ No *(if yes swabs may need to be re-taken, please contact us ASAP)*

Is there anything else that we need to know about that could affect your hospital stay? ○ Yes ○ No if so, please detail: _____

_____

Do you have any disability/mobility restrictions that may affect your hospital stay? ○ Yes ○ No if so, please detail: _____

_____

Do you have any special dietary requirements? (Includes day surgery) _____

ADMISSION FORM PATIENT DETAILS

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PAYMENT DETAILS

St George's Hospital conditions of payment

I understand and agree to the following terms and conditions:
That I will pay my account personally if I do not have prior approval from my insurer, ACC or other funder.

Accounts are due for payment 7 days after date of invoice, unless prior arrangements have been agreed.

If an invoice is not paid within 30 days, interest will be charged at a rate of 1% per month until full payment is received.

The hospital may release such details concerning you to any third party for the sole purpose of collecting any outstanding fees which are owed to the hospital. This may include St George's Hospital obtaining your current credit status.

St George's Hospital may instruct a debt collection agency to recover unpaid invoices. You are liable for all costs and expenses incurred in recovering debt from you (these collection costs will be in excess of 30% of outstanding amounts).

These clauses are intended to be for the benefit of, and are enforceable by, our debt collection agency under the Contracts (Privity) Act 1982.

I HAVE READ AND UNDERSTOOD THE ABOVE CONDITIONS AND I AGREE TO MAKE PAYMENT AS SET OUT ABOVE:

Signature: _____ Print Name: _____ Date: _____

(PERSON RESPONSIBLE FOR PAYMENT MUST SIGN HERE)

IMPORTANT

Are you having more than one operation or procedure during this hospital admission? ◯ Yes ◯ No
If so, are the procedures being paid for by more than one organisation or person? ◯ Yes ◯ No
Examples:
(a) Procedure/s paid for by ACC and a procedure paid for by health insurance
(b) Procedure/s paid for by health insurance and a procedure paid for by yourself
Please note that we need this information to ensure the correct entity is invoiced.
If applicable, please list each procedure and who is paying for it:

_____
_____
_____
_____
_____

St George's Hospital payment details

How will your procedure be paid for? (tick and complete as many as apply)

◯ **Medical Insurance** (personal expenses such as telephone calls may be excluded)

Name of medical insurance company: _____ Membership No: _____

Prior approval for payment? ◯ Yes ◯ No Approval No: _____

Having gained prior approval it is still your responsibility to forward all invoices to your insurer in support of your claim.

◯ **ACC** (personal expenses such as telephone calls or room upgrades may be excluded)
◯ **Personal payment**
◯ **DHB** (personal expenses such as telephone calls or room upgrades may be excluded)
◯ **Prior arrangement**

Billing Name / Address: *(if other than patient)* _____

_____
_____
_____

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Accommodation requirements

Preferred accommodation: (tick where applicable) ◯ Single ◯ Shared ◯ Parent rooming with child

While every effort will be made to meet your requirements, this cannot be guaranteed. ◯ Parent accommodation bed

Please note: If your admission is covered by ACC and you have opted for a single room you will be charged for your upgrade.

I hereby agree to pay St George's Hospital $100 per night to upgrade my room (upgrade subject to availability).

Signature: _____

ACC

◯ Yes ◯ No

If you are fully funded under the ACC Elective Services Contract the following statement does **not** apply.

Please read the following carefully: ACC may not meet the total cost of your operation and as a result there may be significant shortfalls that you will be expected to pay 7 days after the date of invoice *(refer to St George's Hospital Conditions of Payment)*. You will be sent an account showing how the shortfall is made up. If you would like to know how much the shortfall might be, please ask.

STAFF TO AFFIX LABEL HERE

1. **ACC claim no**
2. Area office
3. Case manager

Information regarding insurance / ACC

I give permission for St George's Hospital to obtain any information relating to the approval / claim for this admission from ACC or any medical insurance company and I authorise that person or organisation to disclose such information to St George's Hospital. ◯ Yes ◯ No

I give permission for St George's Hospital to provide information relating to the type of procedure that this consent relates to, to ACC or any medical insurance company for any audit obligations required of St George's Hospital. ◯ Yes ◯ No

Information regarding patient health information & storage

We need to collect and store information about you.
We undertake to:

1. Collect information only when necessary for your treatment.
2. Use information for its intended purpose only (i.e. treatment, administration, teaching, research, ongoing care).
3. Keep information securely in your medical file or in our computer system.
4. Pass on to government bodies only that information to which they are legally entitled.
5. Allow you to check the accuracy of any information about you and to make corrections which you feel are appropriate.

I give permission to St George's Hospital or any independent health clinician 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 St George's Hospital, other health professionals or other health organisations. ◯ Yes ◯ No

Community card holders

Community services No: _____ Expiry date: _____

High user card No: _____ Expiry date: _____

Prescription subsidy card No: _____ Expiry date: _____

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MEDICATION INSTRUCTIONS DISCLAIMER

Medication instructions

To help us to continue your correct routine medications while you are in hospital please obtain a printed list of all your current medications from your pharmacist or General Practitioner (GP).

If you are uncertain about any medications, please contact the clinician's (surgeon/physician) rooms to clarify.

St George's Hospital disclaimer

St George's Hospital is responsible for providing accommodation and nursing services.

All independent health clinicians are health clinicians in private practice and are independent contractors, and **not** agents or employees of St George's Hospital.

St George's Hospital is **not** responsible for any claim, loss or damage arising from;
any medical treatment undertaken by any independent health clinicians or joint venture group comprising of independent health clinicians:
or to patients private property.

I understand and accept that the admitting independent health clinicians using St George's Hospital facilities are separately engaged by me with respect to my medical treatment, care and account payment.

I, (Patient/Parent/Guardian) _____ have read and accept the above St George's Hospital disclaimer.

Signature: _____ Date: _____

It is important that you have a full understanding of the costs involved with hospitalisation. Cost for hospitalisation includes, but is not limited to, your theatre fee, recovery fee, accommodation and medical supplies. We suggest that you consult St George's Hospital and your medical insurance company for full details of benefits and possible gaps prior to admission.

Pre-payment procedures are payable prior to admission to the hospital and a further account may be issued after surgery if the pre-paid amount differs from the actual costs.

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PATIENT LABEL (St Georges to affix)

Clinician's referral letter

This is to confirm the arrangements made for:

_____

To be admitted to hospital on Date: _____ Time: _____ Expected length of stay: _____

Provisional diagnosis / presenting problem: _____

_____

Other conditions present / previous history / other relevant information: (please let us know if the patient has any special needs or requirements)

_____

_____

Specific pre-op instructions: _____

_____

_____

Agreement to treat

1. Planned procedure / treatment: _____

_____

CLINICIAN'S SIGNATURE: _____ Date: _____

I _____ **agree to the planned procedure / treatment as above**

To be performed on me / my child / my ward (state name) _____

by _____ (clinician / surgeon)

2. I also agree to such further alternative operative / investigative measures (including the administration of medications and / or blood transfusions), as may be found necessary during the course of the procedure.

_____ (clinician) has explained to me the reasons for, and the possible risks of the procedure / treatment. I have had adequate opportunity to ask questions and have received all the information that I need.

I understand that I am welcome to ask for more information if I wish.

I understand that appropriate personnel may be present during the procedure / treatment.

3. I agree to the administration of anaesthesia to me / my child / my ward for the above procedure.

I acknowledge that I / my child / my ward should not drive a motor vehicle, not operate machinery or potentially dangerous appliances, drink alcoholic beverages, or make important decisions for 24 hours after having general anaesthetic and / or opioid or sedative agent administered, as mental alertness may be impaired.

4. In the event of a needle stick injury to any health practitioner or employee of St George's Hospital sustained during my hospitalisation, I CONSENT to blood samples being taken for the sole purpose of determining whether I have a transmissible disease (e.g. Hepatitis B, Hepatitis C or HIV) that may be a significant health risk to that employee. I understand that my test results will remain confidential to me and relevant medical practitioners.

I agree that St George's Hospital may access relevant clinical information relating to me, including medication, in order to comply with the Medicine Reconciliation Safety Programme ◯ Yes ◯ No

5. Section 29 Medications: During your procedure at St George's Hospital your clinician may administer medications to you which are referred to as "Section 29 Medications". Section 29 "Medications" refer to medicines (by virtue of section 29, Medicines Act 1981) that have not received formal approval in New Zealand for their use but are nevertheless, considered safe and effective and approved overseas.

The clinician may consider that it is entirely appropriate for the use of Section 29 Medications in your procedure. If a Section 29 Medication is used in your procedure you will be informed post operatively by the clinician and will have the opportunity to discuss the use of this medication with the clinician.

NB: In the event of a medical emergency the clinician will be notified and you may be transferred to Christchurch Hospital for emergency care.

Signature : *(Patient / Parent / Guardian)* _____ **Date:** _____ **Time:** _____

Signature witnessed by: *(can be family member)* _____ **Date:** _____ **Time:** _____

Signed & witnessed for 1, 2, 3, 4 (& 5 if applicable)

CONSENT

CLINICIAN REFERRAL

CONSENT TO TREAT

CONSENT BLOOD/BLOOD PRODUCT TRANSFUSION

ST GEORGE'S HOSPITAL

A TRADITION OF EXCELLENCE

Patient Identification

CONSENT FOR BLOOD / BLOOD PRODUCT TRANSFUSION

PATIENT'S / PARENT'S NAME: _____

PATIENT'S / CHILD'S DATE OF BIRTH: / / _____

If my doctor advises **me / my child** to have a blood transfusion I have read the information provided and have been given the opportunity to discuss the risks, benefits and alternatives to a blood or blood product transfusion.

All my questions have been answered to my satisfaction by: _____

I AGREE / DO NOT AGREE to a blood or blood product transfusion for **me / my child**, should it be considered necessary.

PATIENT / PARENT / GUARDIAN'S SIGNATURE: _____ DATE: / / _____

CLINICIAN'S / NURSE'S SIGNATURE: _____ DATE: / / _____

NZBS Information Leaflet given Yes / No

Clinician's decision to treat

If a patient is unable to provide consent, or no legal representative for the patient is available *(although every possible attempt has been made to contact them)* to help determine what the patient's wishes might be, the decision to administer a blood or blood product transfusion becomes the ultimate responsibility of the clinician caring for the patient.

I *(clinician's name)* _____

consider a blood or blood product transfusion to be necessary for

(Patient's name) _____

although a consent could not be obtained prior to the procedure. In reaching this opinion, I have consulted with another clinician whose signature appears below as a witness.

Signed: _____ Date: / / Time: _____

Witness: _____ Date: / / Time: _____

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ADULT PRE-ANAESTHETIC / MEDICAL QUESTIONNAIRE

Please answer every question if possible.
Withholding medical information may be detrimental to your safety under anaesthesia.

Patient's name: _____

What operation are you booked in for? _____

_____

Attach Label Here

Have you ever had surgery or a procedure requiring an anaesthetic?	◯ Yes	◯ No
Have you ever had a serious or life threatening reaction to anaesthetic?	◯ Yes	◯ No
Is there a history of anaesthetic problems in a family member?	◯ Yes	◯ No
Do you have a stiff neck or problems opening your mouth?	◯ Yes	◯ No
Are you **allergic** to any medications, plasters, latex or food (such as egg, or soy)?	◯ Yes	◯ No

If yes, please list the substance and reaction below.

Substance:	**Reaction:**

Please list any operations that you have previously had with the approximate date, *e.g. Hernia op, St George's, 1998.*

Operation	Hospital	Date

Please list any drugs or medications that you are taking. *Please include prescribed drugs, occasional drugs such as pain relief, antacids, sleeping pills, recreational drugs and any herbal medicines. *Please include contraceptive medications.**
(If you have provided a pharmacy list of your medications please state "see pharmacy list".)

Medication name	Dose	Times per day

Have you had a "head cold", throat infection, or bronchitis in the last 2 weeks? ◯ Yes ◯ No Details

Do you have any anxieties or concerns about your forthcoming anaesthetic that you would like to discuss with your anaesthetist? ◯ Yes ◯ No

Do you suffer from motion sickness? ◯ Yes ◯ No
If yes, is it: Mild / Moderate / Severe (please circle)

Do you wear: Dentures / A partial plate / Contact lenses / Hearing aid? *(please circle one or more)*

Females: Is there any possibility you could be pregnant? ◯ Yes ◯ No

ANAESTHETIC QUESTIONNAIRE

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ANAESTHETIC QUESTIONNAIRE

Do you smoke? If you stopped smoking, when?	◯ Yes ◯ No	If yes, how many per day?
Do you have any asthma, emphysema, chronic bronchitis? *(circle one or more)*	◯ Yes ◯ No	Details:
Do you have any other breathing or lung problems? *Such as shortness of breath, wheezing*	◯ Yes ◯ No	Details:
Do you snore and stop breathing when you sleep?	◯ Yes ◯ No	If yes, have you ever required CPAP?

Do you have high blood pressure?	◯ Yes ◯ No	If yes, are you on treatment?
Do you have angina / chest pain?	◯ Yes ◯ No	If yes, when? Do you take any angina medication?
Have you had a heart attack?	◯ Yes ◯ No	If yes, when?
Do you have heart failure, 'fluid on the lungs' or swollen ankles?	◯ Yes ◯ No	If yes, please detail
Do you have a cardiac pacemaker, defibrillator or cardiac stents? *(circle one or more)*	◯ Yes ◯ No	
Have you ever had a stroke, or mini stroke *(circle one or more)*	◯ Yes ◯ No	If yes, when?

Do you have diabetes? If yes, how is your diabetes controlled *(circle one or more)*	◯ Yes ◯ No	Diet / tablets / insulin
Do you have any problems with your kidneys or bladder?	◯ Yes ◯ No	If yes, please detail
Have you taken steroids such as prednisolone or hydrocortisone in the last 6 months?	◯ Yes ◯ No	If yes, please detail

Do you have indigestion, gastric reflux or hiatus hernia, stomach or peptic ulcer *(circle one or more)*	◯ Yes ◯ No	If yes, are you taking medication?
Do you drink alcohol most days?	◯ Yes ◯ No	If yes, what do you consume each day?
Have you ever had hepatitis, jaundice, or other liver problems? If hepatitis, was it hepatitis A, B, or C *(circle one or more)*	◯ Yes ◯ No	If yes, please detail
Have you ever had any bleeding problems, or family history of bleeding problems?	◯ Yes ◯ No	If yes, please detail
Could you have been exposed to HIV or AIDS?	◯ Yes ◯ No	If yes, do you have HIV or AIDS?
Have you ever had blood clots in your legs or lungs?	◯ Yes ◯ No	
Have you taken any 'blood thinning' mediations (such as aspirin, warfarin, or anti-inflammatory drugs) within the last 2 weeks?	◯ Yes ◯ No	If yes, what have you taken? When?

Do you have epilepsy, blackouts or convulsions? *(circle one or more)*	◯ Yes ◯ No	If yes, are you on treatment?
Do you suffer from depression, anxiety or mental health problems? *(circle one or more)*	◯ Yes ◯ No	If yes, please detail
Do you have any arthritis or painful joints? *(please circle)*	◯ Yes ◯ No	If yes, where

Questionnaire was filled in by: Relationship to patient:

Date:

FOR OFFICE USE ONLY:	Reception check	Date:	Initial:
RN Pre admission check required	◯ Yes ◯ No	Completion date:	Sign:
Admission RN check ◯		Date:	Sign:

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