ST GEORGE'S HOSPITAL

A TRADITION OF EXCELLENCE

FOR OFFICE USE ONLY

NHI number: _____

Admit date: _____ time: _____

Ward/room: _____

Funder: _____

Plan: _____

249 Papanui Rd, Strowan, Christchurch 8014
Private Bag 4737, Christchurch 8140

T: +64 3 375 6000
F: +64 3 375 6340
W: www.stgeorges.org.nz
E: reception@stgeorges.org.nz

Please complete and return via drop off, post or email at least 5 days prior to admission.

To help us care for you during your hospital stay please complete the personal details below

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

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Mstr Other: _____ Gender: _____

Surname: _____ Given names: _____

Preferred name: _____ Any previous name(s): _____

Date of birth: _____ Occupation (optional): _____

Physical address: _____ Postal address (if different to physical): _____

_____ _____

_____ Postcode: _____ _____ Postcode: _____

Contact phone number: _____ Email: _____

Surgeon / Clinician: _____ GP name: _____

Practice: _____

Next of kin / emergency contact (please make sure they are aware of your admission to hospital)

Name: _____ Contact number: _____

Ralationship to patient: _____

NZ resident: ☐ Yes ☐ No

Ethnicity (choose up to 3 if applicable) ☐ New Zealand European ☐ Māori – iwi _____

☐ Samoan ☐ Cook Island Māori ☐ Tongan ☐ Niuean ☐ Chinese ☐ Indian

Other - Please state: _____

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

During the last 12 months, have you travelled to India, Asia, Mediterranean, Balkans, UK or USA ? ☐ No ☐ Yes

Have you been hospitalised anywhere in the last 12 months? ☐ No ☐ Yes

Dietary requirements: ☐ gluten free ☐ wheat free ☐ dairy free ☐ sugar free ☐ nut free ☐ soy free ☐ vegetarian ☐ diabetic

☐ vegan ☐ other (include allergy) _____

Individual care needs; do you currently have any:

Disability, physical support or aids ☐ No ☐ Yes *please detail* _____

_____

Language or interpreter requirements *(we will contact you to discuss this)* ☐ No ☐ Yes *please detail* _____

Bodyparts: If possible would you like these returned? ☐ No ☐ Yes

Is there anything else that we need to know about that could affect your hospital stay? ☐ No ☐ Yes *please detail* _____

_____

Please tick if you would like a visit from our Hospital Chaplain ☐ No ☐ Yes

Kaumatua ☐ No ☐ Yes

Printed June 2019

Clinician to complete:

Admission date: _____ Time: _____

Expected length of stay: _____

Insert patient name label

Provisional diagnosis / presenting problem: _____

_____

Other conditions present / previous history / other relevant information: (please inform St George's Hospital if the patient has any special needs or requirements)

_____

_____

Specific pre-op instructions: _____

_____

Consent

Planned procedure / treatment: _____

_____

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

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

by _____ (clinician / surgeon)

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.

The 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.

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.
In the event of blood or body fluid exposure to any health professional during my stay at St George's Hospital, 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 health professionals.

During my procedure at St George's Hospital clinicians may administer medications to me 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, effective and approved overseas.

The clinician may consider that it is entirely appropriate for the use of Section 29 Medications for my procedure. If a Section 29 Medication has been administered I will be informed by the clinician and will have the opportunity to discuss the use of this medication with the clinician.

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

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

Clinician's signature: _____ Date: _____

Blood / blood product transfusion consent

Patient's/Parent's name: _____ Patient's/child's date of birth: _____

Should the clinician advise that a blood, or blood product, transfusion may be required 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.
I agree/do not agree (please circle) to a blood or blood product transfusion for me/my child/my ward, should it be considered necessary

Patient/Parent/Guardian signature: _____ Date: _____ Time: _____

Clinician/Nurse name: _____ Title: _____

Clinician/Nurse signature: _____ Date: _____ Time: _____

Agreement with St George's Hospital Incorporated ("St George's")

Payment details

Please tick where applicable

☐ ACC ☐ SXAP ☐ DHB ☐ Pre-payment ☐ Personal payment / Private

☐ Insurance * Name of insurance company: _____ Approval number: _____

* Having gained prior approval it is still your responsibility to file a claim with your insurance company.

If you are having more than one procedure, please complete the following:

Procedure	**Payer**
_____	_____
_____	_____
_____	_____

Accommodation (preference - subject to availability)

☐ Single ☐ Shared ☐ Parent bed ☐ Parent lazy boy (no charge)

Please note: If your procedure is covered by ACC and you have opted for a single room you will be charged $100 per night for your upgrade.

Conditions of payment

I understand that I am responsible for any outstanding balance that is not fully covered by ACC, insurance or another funder.

I agree to settle the balance of my account in full within 14 days of invoice date if the account is being paid personally, unless prior arrangements have been agreed.

I understand that the hospital may release such details concerning me to third parties for the sole purpose of collecting any outstanding fees that are owed to the hospital. This may include obtaining my current credit status.

The Hospital may instruct a debt collection agency to recover any outstanding balances. I understand I am responsible for all costs and expenses incurred in recovering these.

I have read, understood and agree to the above conditions and I agree to make payment as set out above:

*Signature: _____ Print name: _____ Date: _____

Billing address: _____

*Person responsible for payment must sign here. Please ensure billing address has been completed

Your health information

We are required to collect and store information about you, we will:

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, electronic system or a third party certified storage facility
4. Pass on to government bodies only that information to which they are legally entitled
5. Make your information available, and enable you to request corrections if you think your information is inaccurate
6. Obtain any information relating to the approval/claim for this admission from any medical insurance company
7. Provide information relating to the type of procedure to ACC or any medical insurance company

I give permission to St George's Hospital, or any independent health clinician involved in my care during this admission, to access health information about me that is relevant to my current treatment. Such information may be held by St George's Hospital, other health professionals or other health organisations.

Signature: _____ Name: _____ Date: _____

ST GEORGE'S HOSPITAL
A TRADITION OF EXCELLENCE

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

Printed June 2019

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? (please circle)
Have you ever had blood clots in your legs or lungs?	☐ Yes ☐ No	
Have you taken any 'blood thinning' mediations (such as aspirin, warfarin, clopidogrel, dabigatran, pradaxa, xarelto or anti-inflammatory drugs) <u>within the last 2 weeks?</u>	☐ 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:

<u>FOR OFFICE USE ONLY:</u>	Reception check	Date:	Initial:
RN Pre admission check required	☐ Yes ☐ No	Completion date:	Sign:
Admission RN check ☐		Date:	Sign:

Printed June 2019

Contracting with St George's Hospital Incorporated ("St George's")

St George's Hospital is responsible for providing hospital care services except in the case of an ophthalmologist employed by St George's Eye Care, your surgeon/clinician is in private practice and is an independent contractor of St George's. Your surgeon/clinician is not acting as an agent of St George's and they are solely responsible for any claim whatsoever relating to medical treatment undertaken by them with your consent (medical treatment)and/or loss or damage to St George's facilities as a result of your medical treatment.

I understand and agree that I have separately engaged my surgeon/clinician to undertake my medical treatment and that my surgeon/clinician has independently contracted with St George's to carry out my medical treatment using St George's Hospital facilities.

I understand and agree that I am solely responsible to pay my surgeon/clinician's account with respect to my medical treatment.

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

Personal property
St George's is not and will not be responsible for loss of or damage to any personal property that I bring to St George's.

Acceptance by patient
I, (Patient/Parent/Guardian) _____ have read and accept the above St George's Hospital terms & conditions.

Signature: _____ Date: _____