ST GEORGE'S HOSPITAL
A TRADITION OF EXCELLENCE

249 Papanui Rd, Strowan,
Christchurch 8014
Private Bag 4737, Christchurch 8140
+64 3 375 6000
www.stgeorges.org.nz
reception@stgeorges.org.nz

Medical forms

Why are the forms so important?

These forms include essential information and important questions about your health history, personal and contact details, consent for treatments and payment arrangements. They also include details of any special needs you may have (which may range from dietary to mobility to cultural and spiritual).

You have been supplied a selection of the following:

- [ ] Hospital registration form
- [ ] Consent form
- [ ] Payment, health information and contracting with St George's Hospital form
- [ ] Health questionnaire

If you have any questions about how to fill them out please do not hesitate to get in touch.

Hand-deliver

You can remove completed forms from your patient information book and hand-deliver to the Hospital Reception at 249 Papanui Rd, Christchurch via Heaton St entrance.

Post

Please remove completed forms from your patient information pack and post to the Hospital at:

St George's Hospital
Private Bag 4737, Christchurch 8140
(please allow up to 5 working days).

Email

Scan or take a photo of each page and email to **reception@stgeorges.org.nz** please ensure to bring original copies with you upon admission.

If you have any questions do not hesitate to get in touch.

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FOR OFFICE USE ONLY
NHI number:
Admit date:

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Hospital registration form

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

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

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Mstr ☐ Mx ☐ Other:

Gender:

Date of birth:

Family name:

Given name:

Preferred name: (optional)

Other given names: (optional)

Physical address:

Contact phone number:

Email:

City:

Post code:

Which ethnic group do you belong to – mark the spaces which apply to you:

☐ New Zealand European ☐ Māori ☐ Samoan ☐ Cook Island Māori ☐ Tongan ☐ Niuean
☐ Chinese ☐ Indian

Other ethnicity(s):

Iwi:

NZ resident:
☐ Yes ☐ No

Residential status if applicable:

Admitting Clinician / Surgeon

Name:

General practitioner

Name: (optional)

Practice: (optional)

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

Name:

Contact number:

Relationship to patient:

Please ensure this form is returned to St George's Hospital at least five (5) business days before admission.

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Consent form

Clinician to complete:

Admission date: Time:

Procedure / surgery date:

Expected length of stay:

Insert patient name label

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:

Operative side of body (please tick): ☐ Left ☐ Right ☐ Bilateral ☐ Not applicable TICK

If the procedure requires removal of tissue or body parts,
do you wish them to be returned to you: ☐ Yes ☐ No ☐ Not applicable TICK

I:

(name of patient or person legally entitled to consent for the patient i.e. parent/guardian, enduring power of attorney for person care and welfare or welfare guardian)

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, as may be found necessary during the course of the procedure. This includes treatment of complications that may result in a return to theatre and/or transfer to another Hospital.

I have been provided with sufficient information in relation to the administration of blood components / blood products / tissue or bone substitutes if necessary. I have been given the opportunity to discuss the risks, benefits and alternatives to a blood components or blood product transfusion / tissue or bone substitutes. All my questions have been answered to my satisfaction.

I consent to the administration of blood components or blood products / tissue or bone substitutes for me / my child / my ward, should it be considered necessary: ☐ Yes ☐ No TICK

(Describe any exceptions regarding blood components or products / tissue or bone substitutes to this consent)

Signature on second page – please turn over

The clinician has explained to me the reasons for, and the possible risks of the procedure / treatment.

The key risks are:

I have been told about additional procedures which may become necessary during the operation / procedure / treatment as described above. I consent to these procedures / treatments. I understand that any further procedures in addition to the procedures described above will only be carried out if it is necessary to save my / the patient's life or prevent serious harm to my / the patient's health. 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 and agree that the procedure / treatment will be provided by a team involving St George's staff and Health Professionals credentialed to work at St George's.

I agree to healthcare students being present/involved in my/my child's/my ward's care: ☐ Yes ☐ No TICK

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 I will be informed of the results of any tests and any need for further medical referral.

I understand I can decline to be informed of the results of the test if I do not want to know the results. I understand that my test results will remain confidential to me, and to the extent it is necessary, the relevant health professionals involved in my care.

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.

If a Section 29 Medication is considered by a clinician as appropriate to administer I will be informed and will have the opportunity to discuss the use of this medication with the clinician.

I have read, understood and agree to the above conditions.

Signature: (Patient / Parent / Guardian) Date:

If applicable please attach evidence of your enduring power of attorney for care and welfare

SIGN HERE

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

SIGN HERE

Clinician name (print): Position:

Clinician's signature: Date:

CLINICIAN SIGN HERE

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Payment of your hospital account

Please indicate how the procedure will be funded (tick all boxes that apply)

☐ **Health insurance** ☐ **ACC** ☐ **Health NZ-Te Whatu Ora** ☐ **Paid personally** ☐ **Other**

Health insurance

Name of Health Insurer:

Approval Number:

Please provide us a copy of your approval prior to your admission. You can email this to **reception@stgeorges.org.nz**

Depending on your health insurance policy or plan you may be required to pay an excess (co-payment).

Estimate of costs

Please contact one of our accounts team on **03 375 6101** to obtain an estimate of the cost, or you can email **ARInc@stgeorges.org.nz**

Please note that the estimate is based on average costs of similar procedures and the actual costs may vary depending on how complex your surgery is.

Payment

You may be asked to make a payment for surgery prior to admission.

Our methods of payment are **EFTPOS, Credit** or **Debit Card**, or **internet banking.**

We will send the invoice to the email address you have provided.

Unless advised otherwise please forward the invoice onto your health insurer.

For self-funding patients, payment is required within 7 days of the invoice date.

IMPORTANT

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

Procedure:	Funded by:

Patient agreement (to be completed by person responsible for payment)

- I agree to settle any balance of my account in full within 7 days of the invoice date.
- I am aware that I am responsible for any outstanding balance that is not fully covered by ACC, insurance, or another funder.
- I agree to make a payment if required towards the estimated cost of my surgery prior to my admission to hospital.
- I understand that the hospital may disclose such details regarding 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 debts. I understand that any debt collection costs will be added to my account.

Please ensure this form is returned to St George's Hospital at least five (5) business days before admission.

I have read and understand the patient agreement information (on previous page)

Name:

Date: dd/mm/yyyy

Signature:

SIGN HERE

If not the patient signing above, please complete **person responsible for payment information** below:

Your relationship to the patient:

Residential address:

Contact telephone number:

Email address:

Your health information

Access, use and disclosure of my / the patient's health information.

- I understand St George's Hospital, the admitting clinician and any member of the healthcare team involved in my care may access health information about me that is relevant to my current admission and treatment, which may be held by St George's Hospital, the admitting clinician, other health professionals, or other healthcare providers.
- I understand that St George's Hospital and/or any member of the healthcare team involved in my care will collect and store information about me, including my health information and images (including photos, videos, or x-rays during my treatment).
- I understand that any information documented, including photographs or recordings taken during my admission will be stored in my clinical file and may be referred to for clinical purposes, and/or audit, and/or teaching, and/or research purposes, and may be disclosed to other health providers who provide services to me and/or my insurer, and/or ACC (delete any that do not apply, or you do not agree to).
- I understand that all information held by St George's Hospital will be kept securely.
- I am aware that I can request more information and ask any questions about St George's Hospital Privacy Policy and how information is collected, stored, used or disclosed by St George's Hospital at any time.

I have read and understood the above information.

Signature:

Print name:

Date:

SIGN HERE

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 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:

Print name:

Date:

SIGN HERE

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Health questionnaire

All questions in this questionnaire are about the person being treated at the hospital.
If you are filling this out on behalf of the patient, only provide information relating to their health.

Patient health history questionnaire completed by (please select):

☐ Patient ☐ Whānau / family member ☐ Health care provider ☐ Other (specify):

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

Family name:

Given name:

General health (this information is important for the anaesthetic)

Height (cm):

Weight (kg):

What operation / procedure are you booked in for?

Please list any procedures / operations / hospital admissions the patient has had
(start with the most recent and work backwards)

Year	Hospital / Clinic	Procedures / Operations / Hospital Admissions

Allergies / reactions

Have you ever had any reactions to **medications, latex, iodine, plasters, food** or any **other substance?**

Item	Reaction
Example: Latex	*Facial swelling and difficulty breathing*

Please ensure this form is returned to St George's Hospital at least five (5) business days before admission.

General health

Please tick **Yes, No** or **Not Sure** for all fields.

Do you currently have, or have you ever had any of the following:	YES	NO	NOT SURE
Surgery or a procedure requiring an anaesthetic	☐	☐	☐
If yes specify: ☐ General ☐ Spinal ☐ Epidural ☐ Unsure			
Problems following an anaesthetic	☐	☐	☐
History of anaesthetic problems in an immediate whānau / family member	☐	☐	☐
Breathlessness climbing 2 flights of stairs	☐	☐	☐
Motion sickness (e.g. car sickness)	☐	☐	☐
If yes specify: ☐ Mild ☐ Moderate ☐ Severe			
Trouble opening your mouth or moving your neck	☐	☐	☐
Concerns about your anaesthetic	☐	☐	☐
Dental work	☐	☐	☐
If yes specify: ☐ Dentures ☐ Plates ☐ Caps ☐ Crowns ☐ Implants ☐ Loose teeth			
Is there a possibility you are pregnant	☐	☐	☐

IF YES OR NOT SURE FOR ANY OF THE ABOVE PLEASE PROVIDE DETAILS

After climbing the stairs of my apartment I am out of breath (Example)

Infection considerations

Please tick **Yes, No** or **Not Sure** for all fields.

Please answer the following:	YES	NO	NOT SURE
In the past 7 days, have you experienced flu-like symptoms, or been in contact with anyone diagnosed with influenza	☐	☐	☐
In the past 4 weeks, have you had a head cold, throat or chest infection, or bronchitis	☐	☐	☐
Have you travelled overseas in the past 12 months	☐	☐	☐
If yes specify where:			
Have you been hospitalised outside of Canterbury in the past 12 months	☐	☐	☐
Have you been diagnosed with TB or Rheumatic fever	☐	☐	☐
Have you ever received treatment for or been diagnosed with an multi drug resistant organism	☐	☐	☐
If yes specify: ☐ MRSA ☐ ESBL ☐ VRE ☐ Norovirus ☐ Other			
Do you currently have any cuts, sores, scratches or other skin or urine infections	☐	☐	☐
Have you recently been exposed to a disease (e.g., measles, RSV, COVID)	☐	☐	☐

IF YES OR NOT SURE FOR ANY OF THE ABOVE PLEASE PROVIDE DETAILS

Heart, lung and sleep health

Please tick the fields that apply.

Do you currently have, or have you ever had any of the following:	
☐ Heart condition	☐ Heart failure
☐ Heart surgery	☐ Rheumatic fever
☐ Palpitations irregular heartbeat	☐ High blood pressure or take medications to control
☐ Heart murmur	☐ Swollen ankles
☐ Angina	☐ Implanted cardiac defibrillator (ICD) or pacemaker
☐ Heart attack	☐ Other
☐ Chest pain	

IF YES OR NOT SURE FOR ANY OF THE ABOVE PLEASE PROVIDE DETAILS

Do you currently have, or have you ever had any of the following:	
☐ Lung surgery	☐ Emphysema
☐ Asthma	☐ COPD
☐ Wheeziness	☐ In hospital for asthma
☐ Bronchitis	☐ Other
☐ Croup	
Is your condition well controlled: ☐ Yes ☐ No	

IF YES OR NOT SURE FOR ANY OF THE ABOVE PLEASE PROVIDE DETAILS

Do you currently have, or have you ever had any of the following:	YES	NO	NOT SURE
A sleep condition	☐	☐	☐
If yes specify: ☐ Sleeplessness ☐ Severe snoring ☐ Obstructive sleep apnoea (or stop breathing while asleep)			
Wake from sleep short of breath	☐	☐	☐
Shortness of breath when lying flat	☐	☐	☐
If yes how many pillows do you sleep with: ☐ 1 ☐ 2 ☐ 3 ☐ More			
A CPAP machine (breathing machine used to keep your airway open while sleeping)	☐	☐	☐
Other	☐	☐	☐

IF YES OR NOT SURE FOR ANY OF THE ABOVE PLEASE PROVIDE DETAILS

Neurological health

Please tick **Yes, No** or **Not Sure** for all fields.

Do you currently have, or have you ever had any of the following:	YES	NO	NOT SURE
Migraines or bad headaches	☐	☐	☐
Stroke (cerebrovascular accident or CVA) or mini stroke (TIA)	☐	☐	☐
Epilepsy or ever had seizures, blackouts or fainting episodes	☐	☐	☐
Memory problems or confusion (e.g., dementia | alzheimer's | forgetfulness)	☐	☐	☐
Muscular or neurological disease	☐	☐	☐
If yes specify: ☐ MS ☐ Parkinson's ☐ Muscular dystrophy			
Severe agitation or confusion while in hospital following surgery	☐	☐	☐

Do you currently have, or have you ever had any of the following conditions:	
☐ Head injury	☐ Anxiety
☐ Concussion	☐ Phobia
☐ Confusion or disorientation	☐ Post-traumatic stress disorder (PTSD)

IF YES OR NOT SURE FOR ANY OF THE ABOVE PLEASE PROVIDE DETAILS

Blood problems

Please tick **Yes, No** or **Not Sure** for all fields.

Do you currently have, or have you ever had any of the following:	YES	NO	NOT SURE
Blood or bleeding conditions	☐	☐	☐
If yes specify: ☐ Anaemia ☐ Unusual bruising ☐ Other			
A blood transfusion	☐	☐	☐
Blood clots in your legs or lungs	☐	☐	☐
If yes specify: ☐ Deep vein thrombosis (DVT) ☐ Pulmonary embolus (PE)			
A family history of blood clots	☐	☐	☐
Reasons which might stop you from accepting a blood transfusion?	☐	☐	☐

IF YES OR NOT SURE FOR ANY OF THE ABOVE PLEASE PROVIDE DETAILS

Additional important information

Please tick **Yes, No** or **Not Sure** for all fields.

Do you currently have, or have you ever had any of the following:	YES	NO	NOT SURE
Diabetes	☐	☐	☐
If yes specify: ☐ Type 1 ☐ Type 2 ☐ Requiring insulin ☐ Requiring tablets ☐ Diet controlled			
Arthritis	☐	☐	☐
Joint replacements	☐	☐	☐
Orthopaedic metal ware	☐	☐	☐
Implants or protheses	☐	☐	☐
Any kidney conditions	☐	☐	☐
Being treated for cancer (currently or previously)	☐	☐	☐
Any stomach or digestive conditions	☐	☐	☐
If yes specify: ☐ Indigestion ☐ Heart burn ☐ Acid reflux ☐ Hiatus hernia ☐ Peptic ulcer			
Any bowel conditions (e.g., irritable bowel syndrome | constipation | bowel disease)	☐	☐	☐
Hepatitis A, B, C, | Jaundice | Liver condition	☐	☐	☐
Thyroid condition	☐	☐	☐
Current pain problems	☐	☐	☐
Conditions that run in your family	☐	☐	☐
If yes specify: ☐ Malignant hyperthermia ☐ Thalassaemia ☐ Muscular dystrophy			
Other conditions that you would like us to be aware of please specify below	☐	☐	☐

IF YES OR NOT SURE FOR ANY OF THE ABOVE PLEASE PROVIDE DETAILS

Personal items

Please tick the fields that apply.

Do you use any of these personal items:	
☐ Mobility aids (e.g. walking stick, walking frame)	☐ Glasses or contact lenses
☐ Hearing aids or cochlear implants	☐ Medic alert bracelet or necklace

IF YES FOR ANY OF THE ABOVE PLEASE PROVIDE DETAILS

Individual needs

Please tick the fields that apply.

Do you have any individual needs / requirements:	
☐ Disability	☐ Other communication issues
☐ Physical support or aids	☐ Language or interpreter

IF YES FOR ANY OF THE ABOVE PLEASE PROVIDE DETAILS

Do you:	YES	NO
Have an advance care plan or advanced health directive	☐	☐
Have an Enduring Power of Attorney (EPA) for personal care and welfare	☐	☐
Currently use any community support services	☐	☐
Live alone	☐	☐
Have a responsible adult to drive you home following your surgery	☐	☐
Have someone to stay overnight with you when you get home	☐	☐
Live in a retirement home, long term care facility or other	☐	☐
Have anxieties, concerns, or questions you wish to discuss before your procedure	☐	☐

IF YES FOR ANY OF THE ABOVE PLEASE PROVIDE DETAILS

Please answer the following:	YES	NO
Do you have religious or spiritual needs	☐	☐
Do you have cultural or family / whānau needs	☐	☐
Kaumātua is available for karakia - Would you like a visit from our Hospital Kaumātua while you are in hospital or would you like assistance facilitating a visit from your own	☐	☐
Would you like a visit from our Hospital Chaplain while in hospital	☐	☐
If you live outside of Christchurch, will you be staying in Christchurch the night before your surgery	☐	☐
Have you had a fall in the last 3 months	☐	☐

IF YES FOR ANY OF THE ABOVE PLEASE PROVIDE DETAILS

Dietary requirements:	YES	NO
Do you have any dietary requirements or food allergies	☐	☐
If yes specify: ☐ Diabetic ☐ Vegetarian ☐ Gluten Free ☐ Vegan ☐ Halal ☐ Other		

IF YES FOR ANY OF THE ABOVE PLEASE PROVIDE DETAILS

Lifestyle

Please tick **Yes,** or **No** for all fields.

Please answer the following:	YES	NO
Do you drink alcohol daily	☐	☐
Are you a former smoker	☐	☐
Are you a current smoker (including vaping)	☐	☐
Are you currently on smoking cessation treatment	☐	☐
Do you use recreational / non-prescribed medication	☐	☐

IF YES OR NOT SURE FOR ANY OF THE ABOVE PLEASE PROVIDE DETAILS

Medications

Please tick the fields that apply.

Do you take medications or remedies for any of the following:	YES	NO
Blood thinning (e.g. warfarin, aspirin, clopidogrel)	☐	☐
Heart disease or high blood pressure	☐	☐
Diabetes: Gliflozin (Jardiance), Insulin or other	☐	☐
Sleeplessness	☐	☐
Depression or anxiety	☐	☐
Epilepsy	☐	☐

Do you take:	
☐ Oral contraception or hormone replacement therapy	☐ Cortisone (steroids)
☐ Anti-inflammatories	

IF YES OR NOT SURE FOR ANY OF THE ABOVE PLEASE PROVIDE DETAILS

Your current medicines

To help us to continue with 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). You can either list your medications in the table below or upload a picture of your printed list, medicine pottles or yellow card if completing your form online.

Please include prescribed drugs, occasional drugs such as pain relief, antacids, sleeping pills, recreational drugs, contraceptive medicines, rongoā and herbal medicines.

Name of medicine / supplement	How much you use, and when	Strength

Please let your surgeon know if you think you are getting a cold, flu or illness or if you start taking any new medications prior to your procedure.

St George's Hospital use only

Health questionnaire assessed by:

Name: _____ Position: _____ Date: _____

Pre-anaesthesia requirements: (please tick all the fields that are required)

- ☐ Proceed to admission
- ☐ RN assessment in clinic required
- ☐ RN assessment via telephone required
- ☐ ICU / HD care required

*Action requirements as per procedure and complete appropriate documentation

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