

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: 02-0191-0522222-00 | 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. 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, or post the forms. If you post the forms, please allow 1-2 extra weeks for delivery.

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) _____

Height _____ metres _____

Weight _____ kilograms _____ Surgeon _____

Occupation (optional) _____ NHI (if known) _____

Hospital Administration only
(Patient label)

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 moderate severe
<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:

SECTION A : YOUR GENERAL HEALTH (continued)

A2: YOUR MEDICAL CONDITIONS

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 |
|--------------------------|--------------------------|--|--------|
| <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 pain congestive 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 in the comments box | |
| <input type="checkbox"/> | <input type="checkbox"/> | 44. Other condition(s) not listed above: Other condition(s) not listed above – If Yes, please specify in the comments box below | |

YOUR COMMENTS

Surname (family name)

Hospital Administration only
(Patient label)

First name (s)

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
Skinrelated		
Medicinerelated		
Foodrelated		
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	If Yes
<input type="checkbox"/>	<input type="checkbox"/>	47. Do you have a disability?	Specify:
<input type="checkbox"/>	<input type="checkbox"/>	48. Do you have ? Your preferred language:	Your preferred language:
<input type="checkbox"/>	<input type="checkbox"/>	49. Do you have any religious or spiritual needs you would like us to know about?	Specify:
<input type="checkbox"/>	<input type="checkbox"/>	50. Do you have any cultural or family needs you would like us to know about?	Specify:
<input type="checkbox"/>	<input type="checkbox"/>	51. Do you have any other special needs you would like us to know about?	Specify:
<input type="checkbox"/>	<input type="checkbox"/>	52. If your procedure requires the removal of body parts, would you like them returned to you if this is possible?	
<input type="checkbox"/>	<input type="checkbox"/>	53. Do you have any dietary requirements? vegetarian / vegan / diabetic / gluten free / halal / dairy free / other	
<input type="checkbox"/>	<input type="checkbox"/>	54. Do have any specific food dislikes	Specify:

For allergies or intolerances, refer to question 46

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

Surname (family name)

First name (s)

Hospital Administration only
(Patient label)

SECTION D: YOUR CURRENT MEDICINES

For your safety, it is extremely important that your doctors and nurses know precisely which medicines you are currently using. Important instructions.

1. List below all medicines you currently use, and bring them with you to the hospital in their original containers
2. To ensure you are clear what to include, please use the MEDICINE REMINDERS table
3. If you have a medication card or printout from your GP or pharmacist, please bring it with you to the hospital, as well as completing the list below.

MEDICINE REMINDERS Which of the examples below apply to you?		
There are many types of medicine	Medicines come in many forms	Medicines are taken for many common conditions
prescription medicines, herbal medicines, natural medicines, homeopathic remedies, over-the-counter medicines, vitamins, supplements, contraceptives, steroids	tablets, capsules, inhalers, drops, syrups, patches, suppositories, creams, injections, other liquids	heart disease, high blood pressure, blood thinning, emotional conditions, infections, diabetes, sleeplessness, epilepsy

D1. YOUR CURRENT MEDICINES			HOSPITAL USE ONLY					
Patient to complete - list all medicines you currently use.			Reconciled: Yes (Y) No (N) Not Available (NA)				Comment if No	On Admission: Date/Time last taken
Name of Medicine	Strength	How much you use, and when	Medicine Container	Medication Card	Patient or Whānau/family	Other (state) eg. 'phoned GP'		
Example - Paracetamol	500mg	2 capsules every 6 hours	-	-	-	-	-	-