Forms to complete

Please complete and return this form to Ormiston Hospital at least seven days prior to procedure.

EMAIL endoscopy@ormistonhospital.co.nz
DELIVER Ormiston Hospital, Level 3, 125 Ormiston Road, Flat Bush, Auckland 2016
For enquiries please phone enquiries (09) 250 1157 (Option 2)

Ormiston Hospital resepctsyour rights against the Health Information Policy Code and the Privacy Act. All personal information and data collected is for the purpose of your treatment, to assist quality assurance and to fulfil legislative requirements. If you have any queries or concerns regarding this please contact the Hospital.

PATIENT ADMISSION FORM

Surname (family name): ______________ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Mstr ☐ Dr ☐

First name(s): ______________ Preferred name: ______________

Date of birth: ______________ NHI: ______________

Address (usual place of residence): ______________

Email address: ______________ Mobile: ______________

New Zealand resident: ☐ Yes ☐ No

Next of Kin: ______________ Relationship: ______________

Preferred contact number: ______________

Date of procedure : ______________ Time: ______________

Endoscopist if known: ______________ General Practitioner Name: ______________

Medical Centre: ______________ Health Insurance: ______________

Membership Number: ______________ Have you obtained “prior approval” for payment: ☐ Yes ☐ No

I ACKNOWLEDGE THAT:

I am responsible for any accounts relating to this admission.
I will settle the account prior to discharge unless other arrangements have been made.
I will be responsible for any debt collection costs incurred.

While every care will be taken with your essential items e.g. spectacles, wallet, watch, etc. we request that you leave other valuables at home. Ormiston Hospital is unable to take responsibility for these items.

I give permission for Ormiston Hopsital 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 Ormiston Hospital, other health professionals or health organisations.

I AGREE THAT I HAVE READ AND UNDERSTOOD THE ABOVE STATEMENTS:

Patient’s signature: ______________ Date: ______________

If not patient, please state your relationship to the patient: ______________

Patient Health Questionnaire

All questions in this questionnaire are about the person being treated at the hospital. If you are filling this out for your child, only provide information relating to the child's health

Do you have any allergies? ☐ Yes ☐ No (If Yes, please Specify) ______________________

Weight (approx.) ______________ **Height** (approx.) ______________

Do you have any metal implants or metalware on your body? ______________________

YES	NO	DO YOU HAVE ANY MEDICAL CONDITIONS?	TYPE OR DETAILS
☐	☐	Diabetes	Diet Control ☐ Tablets ☐ Insulin ☐
☐	☐	High Blood Pressure	
☐	☐	Arrythmias (irregular heart rate)	
☐	☐	Pacemaker	Pacing ☐ Defibrillator ☐
☐	☐	Blood thinning medication	
☐	☐	Cardiac (Heart) Conditions	
☐	☐	Stroke/TIA (Transient ischemic attack)	
☐	☐	Epilepsy	
☐	☐	Obstructive Sleep Apnoea	
☐	☐	Respiratory (Lung) Conditions (Asthma, COPD)	
☐	☐	Gastrointestinal conditions (GORD, IBS, IBD)	
☐	☐	Bleeding problems or blood clots	
☐	☐	Organ transplant/Immunosuppression	
☐	☐	Cancer treatment +/- chemotherapy or radiotherapy	
☐	☐	Mult resistant Organisms: MRSA, ESBL, VRE, CPE	
☐	☐	Aware you are pregnant	
☐	☐	Any other illness or condition we should be aware of (Liver or kidney disease, Parkinson's, dementia, Alzheimer's, malignant hypothermia, glaucoma, prostate problems...)	

YES	NO	YOUR NEEDS AND PREFERENCES	DETAILS
☐	☐	Do you have a disability or need support with mobility?	
☐	☐	Do you have difficulty understanding English?	Your preferred language
☐	☐	Do you have any religious or spiritual needs?	
☐	☐	Do you have any cultural or family needs?	
☐	☐	Do you have any dietary requirements?	
☐	☐	Do you have any other special needs you would like us to know about?	

Medications (list all tablets, inhalers, injections or supplements) OR send in a printed list	Previous Endoscopies, abdominal surgery or major surgery

Is there any other information you would like us to be aware of?

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