"Enhancing Health through clinical excellence"

"Kia Rangatira ai nga Huarahi Hauora"

ADMISSION FORM

Please complete and return to the hospital seven days prior to admission.

Kensington Hospital, 12 Kensington Avenue, Whangarei 0112 Phone 09 437 9080, Fax 09 437 9081

Personal Details

Surname ______ First name(s) ______

Preferred Name ______ ○ Male ○ Female

Date of birth ______ Age ______ Ethnicity ______

Address ______ Postcode ______

Postal Address ______ Are you a NZ resident? ○ YES ○ NO

Phone Number Home ______ Business ______ Mobile ______

Email Address ______ Your family Doctor ______

Allergies/Medical Alert

Do you have allergies to medications, tablets, plasters, food, LATEX or any other substance? ○ YES ○ NO
If "YES" please list below.

Substance	Type of reaction	Substance	Type of reaction

Admission Details: (For office use only)

Special Instructions: ______

Date of Operation ______ Time ______ Number of Nights ______

NHI Number ______ Surgeon ______ Anaesthetist ______

Proposed surgery ______

LA/GA/SEDATION Day Case YES / NO IPS Bed Required YES / NO

Health Questionnaire

Please complete the following questions. They help provide our staff with necessary information to assess your health and plan your care. This information will remain confidential and form part of your medical records.

Your weight ______ **kg** **Your height** ______ **metres**

Have you ever had any previous operations? ◯YES ◯NO

Please detail ....

....

Have you or any of your family been told of any difficulties during your anaesthetic? ◯YES ◯NO

If yes please detail ....

Have you ever suffered from post operative nausea / vomiting or motion sickness? ◯YES ◯NO

Do you suffer from, or have you ever suffered from any of the following?	YES	NO	COMMENTS
Heart disease, e.g. chest pain, rheumatic fever, heart attack, angina	◯	◯	....
Heart murmur, palpitations	◯	◯	....
Cardiac surgery ie. stents, Internal defibrillator, pacemaker, heart valves	◯	◯	....
High blood pressure	◯	◯	....
Lung disease e.g. Asthma, breathing troubles, TB	◯	◯	....
Obstructive sleep apnoea	◯	◯	....
Hiatus hernia, Indigestion	◯	◯	....

Do any of the above restrict your activity?	YES	NO	COMMENTS
Liver disease e.g. jaundice, hepatitis B	◯	◯	....
Kidney disease	◯	◯	....
Abnormal bruising or bleeding	◯	◯	....
Anaemia and other blood disorders	◯	◯	....
Blood clots (legs or lungs)	◯	◯	....
Diabetes	◯	◯	TYPE:......................
Epileptic fits	◯	◯	....
Migraines or severe headaches	◯	◯	....
Substance dependency e.g. morphine	◯	◯	....
HIV or Hepatitis C	◯	◯	....
Stroke, CVA, TIA, (Transient Ischaemic Attack)	◯	◯	....
Dementia	◯	◯	....
Mental illness requiring treatment	◯	◯	....
Do you have problems with your neck or opening your mouth?	◯	◯	....
Spinal problems (e.g. surgery)	◯	◯	....

General Questions

	YES	NO	COMMENTS
Do you smoke? If yes, how many per day?	◯	◯	....
Do you drink alcohol every day? If yes how much per day?	◯	◯	....
Have you had MRSA/ESBL/ VRE/ a hospital borne infection?	◯	◯	....
Have you been a patient/employee in a hospital in the last 6 months?	◯	◯	....
Do you have any special dietary requirements?	◯	◯	....
Do you suffer from any other condition, not covered elsewhere that you feel we should know about?	◯	◯	....
Women only. Could you be pregnant?	◯	◯	....

Patient Medications

Do you regularly take any pills, potions, medicines or drugs (including homeopathic and natural remedies)? Please list below all medications you are taking or detail on a separate sheet. Please discuss with your surgeon which medications you will need to take or withhold on the day of surgery (e.g. Warfarin, diabetic medications etc.) If you are staying in overnight, could you please attach a list of your current medicines from your pharmacy/GP and bring your medicines in with you. ◯ YES ◯ NO

Medication	Dose	Times Taken	Medication	Dose	Times Taken
....	....	....	....	....	....
....	....	....	....	....	....
....	....	....	....	....	....
....	....	....	....	....	....

Name of your usual Pharmacy .... Phone Number..

Are you taking any anticoagulants or blood thinning medications? eg: Warfarin, Dabigatran, Clopidogrel etc.

◯ YES ◯ NO TYPE: ....

Social

	YES	NO	
Do you use any mobility aids, ie. walking frame / wheelchair / hoist?	◯	◯	TYPE: ....
Do you have any difficulties with any activities of daily living e.g. dressing/housework/showering? If yes, please give further details.	◯	◯	

....

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....

Do you currently receive any community services, ie. Homehelp? If yes, please give further details. ◯ ◯

....

....

Do you have any dependents that need assistance? If yes, please give further details. ◯ ◯

....

....

Do you live alone? ◯ ◯

Who will care for you on discharge for the first 24 hours? (must be 16 years or over).

Name: .... contact details:....................................

Who will take you home on discharge?

Name: .... contact details:....................................

Special requirements (e.g. visual or hearing difficulties, cultural needs) ◯ ◯

If so, please outline.

....

....

Religious considerations ◯ ◯

If so, please outline.

....

....

Do you require an interpreter? If yes, what language? . ◯ ◯

....

Next of Kin / Contacts

1) Contact Person ____ Relationship ____

Address ____ Number where staying whilst you are in hospital ____

Phone Number Home ____ Business ____ Mobile ____

2) Contact Person ____ Relationship ____

Address ____ Number where staying whilst you are in hospital ____

Phone Number Home ____ Business ____ Mobile ____

Payment Details

Have your hospital costs been approved by:

- ◯ Medical Insurance: Name of Company ____
- ◯ Self
- ◯ ACC ACC Claim No. ____ App No. ____

ACC Injury Date. ____ OP Code. ____

I agree that I am responsible and will pay for all costs incurred in connection with my treatment, that are not covered by other parties (ie ACC, Medical Insurance). Overdue accounts will incur debt collection fees.

Are you on Weekly Compensation from ACC? ◯ YES ◯ NO

Health Information Privacy Explanation

Under the provisions of the Health Information Privacy Code 1994 there is a requirement to collect and store information about each patient to help provide good and safe treatment. It is mandatory to send certain health information to other organisations such as the Ministry of Health. Your medical records will be kept secure and will only be accessed by authorised personnel. You as a patient, have the right of access to your notes for as long as Kensington Hospital stores them. During this time, if you desire, you can update or correct your medical notes. Requests for access to your notes should be made through our Privacy Officer.

On the day of your operation until you are able to receive phone calls, our reception or nursing staff will provide callers with a general statement regarding your health, unless advised otherwise.

If you do not wish to have any information disclosed about your stay - please inform us on admission.

If for any reason you require to be transferred to another hospital a copy of your notes from Kensington Hospital will accompany you. A copy of the Health Information Privacy Code is available for further information if desired.

I consent to Kensington Hospital obtaining my (or my childs) medical records and investigation results (eg lab tests, radiology), and to collect and store health information for the purpose of assisting in my (or my childs) care and treatment, and in administering and monitoring this care. Kensington Hospital may share any information that is directly related to my healthcare with third parties, such as health insurers, medical specialists, and ACC.

You will be contacted pre-operatively to discuss your admission. If you are unreachable:
Do you give consent for a message to be left on your answer phone. YES / NO (please circle)

If you have not received a pre-operative phone call 24 hours prior to your admission date, please contact Kensington Hospital at your earliest convenience.

Sign here ____ Date ____

Please print name ____

The above details have been completed by: ◯ patient ◯ guardian ◯ relative ◯ other (specify) ____