

ST GEORGE'S HOSPITAL CONFIDENTIAL ADMISSION FORM



**ST GEORGE'S
HOSPITAL**

A TRADITION OF EXCELLENCE

- ☐ **MAIN HOSPITAL ENTRANCE** - Heaton Street
☐ **DAY SURGERY ENTRANCE** - Leinster Road

**THIS FORM NEEDS TO BE
COMPLETED AND RETURNED
TO THE HOSPITAL AT LEAST
3 WORKING DAYS PRIOR
TO ADMISSION.**

FOR OFFICE USE ONLY

ADMISSION DATE _____
ADMISSION TIME _____
WD/RM _____
NHI _____
ACC ☐ YES ☐ NO

PERSONAL DETAILS - (to be filled in by patient or parent/guardian) No labels please

Surname: (Family Name) _____ Mr/Mrs/Miss/Ms/Mstr/Other: _____
Given Names: _____ Preferred Name: _____
Previous / Maiden Names: _____ Occupation: _____
Address: _____ Phone: _____
Suburb: _____ Work: _____
City: _____ Postcode: _____ Cell / Alternative: _____
Email Address: _____
Date of Birth: _____ ☐ Female ☐ Male Religion (optional) _____
Surgeon / Clinician _____ GP: _____
Our Hospital Chaplain is available to all. Please indicate if you would like a visit: ☐ Yes ☐ No

THIS INFORMATION IS REQUIRED FOR STATISTICAL PURPOSES

☐ Married ☐ Single ☐ De Facto ☐ Divorced ☐ Separated ☐ Widow / Widower ☐ Other: _____

Country of Birth: _____ New Zealand Residency Status: ☐ Yes ☐ No

First Language: (if not English) _____ Do you require a Translator: (enquire re fee) ☐ Yes ☐ No

Which ethnic group do you belong to? Mark the space or spaces that apply to you.

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

Other (such as Dutch, Japanese, Tokelauan). - Please state: _____

CONTACT DETAILS / PREVIOUS HOSPITAL HISTORY / ACCOMMODATION REQUIREMENTS

Contact Name: _____ Relationship: _____

(Would you like the surgeon to contact this person after the surgery if possible? Please note not all surgeons offer this service) ☐ Yes ☐ No

Address: _____

Telephone No. Home: _____ Work/Cell Phone: _____

Alternative Contact Name: _____ Telephone No: _____

Have you been admitted to any hospital in the last ten years? ☐ Yes ☐ No

If yes, where? _____ Under what name: _____

Have you ever had contact with MRSA? ☐ Yes ☐ No (if yes swabs may need to be re-taken, please contact us ASAP)

Preferred Accommodation: (tick where applicable) ☐ Single ☐ Ward ☐ Parent rooming with child

While every effort will be made to meet your requirements, this cannot be guaranteed. ☐ Parent accommodation bed

Other Requirements: _____ Special Dietary Requirements: _____
(including Impairments / Disabilities)

The hospital will forward all phone calls for you to your bedside phone. If you do not wish this to happen please contact the hospital to organise for alternative arrangements.

ADMISSION FORM

CLINICIAN'S REFERRAL LETTER

This is to confirm the arrangements made for:

To be admitted to hospital on date:

Time:

Provisional Diagnosis / Presenting Problem:

Other conditions present / previous history / other relevant information: (please let us know if your patient has any special needs or requirements)

Specific Pre-Op Instructions:

Allergies:

Pre-operative tests required: (please tick here if required)

☐ Radiology

☐ ECG

☐ Pathology

☐ MRSA swabs arranged (if appropriate)

AGREEMENT TO TREAT

1. Planned Procedure / Treatment:

CLINICIAN'S / SURGEON'S SIGNATURE:

Date:

I agree to the planned procedure / treatment as above.

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

By (Clinician / Surgeon)

2. 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.

Dr / Mr (Clinician / Surgeon) 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 other appropriate personnel may be present during the procedure / treatment.

3. 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 had a general anaesthetic and / or opioid or sedative agent administered, as mental alertness may be impaired.

4. In the event of a needle stick injury to any health practitioner or employee of St George's Hospital sustained during my hospitalisation, I CONSENT to blood samples being taken for the sole purpose of determining whether I have a transmissible disease (eg. Hepatitis B, Hepatitis C or HIV) that may be a significant health risk to that employee. Your test results will remain confidential to you and your medical practitioner.

I agree that St Georges Hospital may access information relating to my medication, in order to comply with the Medicine Reconciliation Safety Programme ☐ Yes ☐ No

(If you are a Cardiac patient)

5. I accept the following risks exist:

Cardiac Catheterisation: Haematoma (large bruise) at the puncture site - 5%, repair of artery at puncture site - 1%

Stroke, heart attack, kidney failure - 1:1000, death - 1:2000

Coronary Angioplasty: Heart attack 2%, need for emergency heart surgery 0.4%, death 0.2%

NB: In the event of a medical emergency your surgeon will be notified and you may be transferred to Christchurch Hospital for emergency care.

Signature : (Patient / Parent / Guardian)

Date:

Time:

Signature witnessed by: (can be family member)

Date:

Time:

Signed & witnessed for 1, 2, 3, 4 (& 5 if applicable)

CONSENT

ACC

☐ Yes ☐ No

If you are fully funded under the ACC Elective Services Contract the following statement does **not** apply.

Please read the following carefully: ACC may not meet the total cost of your operation and as a result there may be significant shortfalls that you will be expected to pay 7 days after date of invoice (*refer to St George's Hospital Conditions of Payment*). You will be sent an account showing how the shortfall is made up. If you would like to know how much the shortfall might be, please ask.

PLACE STICKER HERE!

1. ACC Claim No
2. Area Office
3. Case Manager

I hereby agree to pay St George's Hospital _____ per night to upgrade my room from a shared ward to a single room if available.

Signature: _____

INFORMATION REGARDING INSURANCE / ACC

I give permission for St George's Hospital to obtain any information relating to the approval / claim for this admission from ACC or any Medical Insurance Company and I authorise that person or organisation to disclose such information to St George's Hospital. ☐ Yes ☐ No

I give permission for St George's Hospital to provide information relating to the type of procedure that this consent relates to, to ACC or any Medical Insurance Company for any audit obligations required of St George's Hospital. ☐ Yes ☐ No

ST GEORGE'S HOSPITAL DISCLAIMER

St George's Hospital is responsible for providing accommodation and nursing services.

All independent health clinicians are health clinicians in private practice and are independent contractors, and **not** agents or employees of St George's Hospital.

St George's Hospital is **not** responsible for any claim, loss or damage arising from any medical treatment undertaken by any independent health clinicians or joint venture group comprising of independent health clinicians.

I understand and accept that the admitting independent health clinicians using St George's Hospital facilities are separately engaged by me with respect to my medical treatment, care and account payment.

I, (Patient/Parent/Guardian) _____ have read and accept the above St George's Hospital disclaimer.

Signature: _____ Date: _____

It is important that you have a full understanding of the costs involved with hospitalisation. Cost for hospitalisation includes but is not limited to your theatre fee, recovery fee, accommodation and medical supplies. We suggest that you consult St George's Hospital and your Medical Insurance Company for full details of benefits and possible gaps prior to admission.

Pre-payment Procedures are payable prior to admission to the hospital and a further account may be issued after surgery if the pre-paid amount differs from the actual costs.

ST GEORGE'S HOSPITAL PAYMENT DETAILS

How will your procedure be paid for? (tick and complete as many as apply)

☐ **Medical Insurance** (personal expenses such as telephone calls may be excluded)

Name of Medical Insurance Company: _____

Membership No: _____

Prior Approval for Payment?

☐ Yes

☐ No

Approval No: _____

Having gained prior approval it is still your responsibility to forward all invoices to your insurer in support of your claim.

☐ **ACC** (personal expenses such as telephone calls or room upgrades may be excluded)

☐ **DHB** (personal expenses such as telephone calls or room upgrades may be excluded)

☐ **Personal Payment**

☐ **Prior Arrangement**

Billing Name / Address: *(if other than patient)* _____

ST GEORGE'S HOSPITAL CONDITIONS OF PAYMENT

I understand and agree to the following terms and conditions:

That I will pay my account personally if I do not have prior approval from my insurer, ACC or other funder.

Accounts are due for payment 7 days after date of invoice, unless prior arrangements have been agreed.

Interest is charged at a rate of 1% per month if overdue invoice is not paid within 30 days from date of invoice, to be charged until full payment.

The Hospital may release such details concerning you to any third party for the sole purpose of collecting any outstanding fees which are owed to the Hospital. This may include St George's Hospital obtaining your current credit status.

St George's Hospital may instruct a debt collection agency to recover unpaid invoices. You are liable for all costs and expenses incurred in recovering debt from you (these collection costs will be in excess of 30% of outstanding amounts).

These clauses are intended to be for the benefit of, and enforceable by, our debt collection agency under the Contracts (Privity) Act 1982.

I HAVE READ AND UNDERSTOOD THE ABOVE CONDITIONS AND I AGREE TO MAKE PAYMENT AS SET OUT ABOVE:

Signature: _____

Print Name: _____

Date: _____

(PERSON RESPONSIBLE FOR PAYMENT MUST SIGN HERE)

IMPORTANT!

Are you having more than one operation or procedure during this hospital admission?

☐ Yes ☐ No

If so, are the procedures being paid for by more than one organisation or person?

☐ Yes ☐ No

Examples:

(a) Procedure/s paid for by ACC and a procedure paid for by health insurance

(b) Procedure/s paid for by health insurance and a procedure paid for by yourself

Please note that we need this information to ensure the correct entity is invoiced.

If applicable, please list each procedure and who is paying for it:

INFORMATION REGARDING PATIENT HEALTH INFORMATION & STORAGE

We need to collect and store information about you.

We undertake to:

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 or in our computer system.
4. Pass on to Government bodies only that information to which they are legally entitled.
5. Allow you to check the accuracy of any information about you and to make corrections which you feel are appropriate.

I give permission to St George's Hospital or any independent health clinician 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 St George's Hospital, other health professionals or other health organisations.

☐ Yes ☐ No

COMMUNITY CARD HOLDERS

Community Services No:

Expiry Date:

High User Card No:

Expiry Date:

Prescription Subsidy Card No:

Expiry Date:

MEDICATION INSTRUCTIONS

Please obtain a printed list of all your prescription medicines from your Pharmacist or General Practitioner.

Attach this list to your admission form or bring in with you on the day of admission together with the medications you are currently taking in their original packaging, as well as any alternative, non-prescription, dietary supplements or herbal medications. This also applies to medications issued in a Blister Pack.

Please check with your Consultant whether there are any medications that you should stop prior to your surgery or procedure, especially if you are taking Anticoagulants (Warfarin and Heparinoids blood thinning agents). Anti-inflammatory drugs (including Aspirin), Diuretics (fluid pills), oral diabetic drugs or insulin.

Unless otherwise instructed by your Doctor / Specialist, all routine medications should be continued pre-procedure. It should be taken at the usual time.

Thank you for your assistance in helping us to continue your correct routine medications while you are in hospital.

PRE-ANAESTHETIC QUESTIONNAIRE

(for Adults or Children)

Fill in for patient only

Patient's Name: _____ Proposed Operation: _____

Address: _____

Age: _____ Surgeon: _____ General Practitioner: _____

Occupation: _____

Questionnaire was filled in by: _____ Date: _____

Relationship to patient: _____

WITHHOLDING MEDICAL INFORMATION MAY BE DETRIMENTAL TO YOUR (CHILD'S) SAFETY UNDER ANAESTHESIA

YES

NO

PLEASE TICK A **YES** OR **NO** IN EACH LINE, CIRCLE A WORD WHERE APPROPRIATE,
AND WRITE ANY COMMENTS IN THE SPACE PROVIDED

Have you / your child or any of your family ever had special difficulties or problems with anaesthetics?
Please specify: _____

List all operations you have had / your child has had (with approximate year).

Please list any previous operations you have had.

Year	Operation

Please bring a typed list of your current medications.

YES

NO

HAVE YOU / HAS YOUR CHILD EVER HAD:

Diabetes; Controlled by diet alone / tablets / insulin

High Blood Pressure; currently on medication

☐ Yes

☐ No

Stroke / TIA (Transient Ischaemic Attack)

Angina / Heart Attack / Heart Failure

☐ Yes

☐ No

Pacemaker / Internal Defib / Implant / Cardiac Stents

☐ Yes

☐ No

List (type): _____

Heartburn / Acid Reflux / Hiatus Hernia / Stomach or Peptic Ulcer

Asthma / Emphysema / Chronic Bronchitis

Tuberculosis / Rheumatic Fever / Heart Murmur

Jaundice / Hepatitis A B or C. Are you a carrier?

☐ Yes

☐ No

Blood Clots in legs or lungs

Arthritis: If yes, which joints are mainly affected?

Any bleeding problems / Family history of bleeding problems

Any risk of HIV / CJD / other transmittable diseases exposure?

Any other illness: Please specify

E.g.: Epilepsy

Kidney problems

Muscular Dystrophy

Creutzfeldt Jakob Disease (C.J.D.)

PLEASE TURN OVER PAGE TO COMPLETE FORM

ANAESTHESIA FORM

YES	NO	
		Do you suffer from motion sickness? Mild / Moderate / Severe
		Do you smoke? If so, how many per day? (NB: Your Anaesthetist strongly advises that you stop smoking immediately)
		Have you ever smoked?
		Do you have some alcohol every day? If yes, how much?
		Do you wear: Dentures A partial plate Contact lens Hearing aid? (please circle)
		Females: (1) Is there any possibility you could be pregnant?
		(2) Are you on contraceptive pill?

YES	NO	IN THE PAST YEAR HAVE YOU / HAS YOUR CHILD EVER HAD:
		Wheeziness or Croup?
		Shortness of breath on slight exertion, or at night?
		Pain in the chest? Tightness in chest or arms?
		Unusual thumping or beating of the heart?
		Swollen ankles?
		Blackouts? Convulsions? Apnoea attacks (loss of breathing)?

YES	NO	HAVE YOU / HAS YOUR CHILD EVER TAKEN:
		Drugs for thinning the blood (anti-coagulants)
		Drugs for heart disease
		Drugs for high blood pressure
		Diabetes medication - tablets or insulin injections
		Cortisone type drugs - steroids
		Anti-inflammatory drugs
		Drugs for epilepsy
		Drugs for “nerves” or sleeplessness

Please list all medicines, tablets (herbal or complementary), inhalers, injections you have / your child has taken in the past 4 weeks. It is a requirement that you bring a list of prescribed medications with you either from your Pharmacist or GP.	

YES	NO	
		Have you / has your child had a “head cold”, throat infection, or bronchitis in the last 2 weeks?
		Have you / has your child taken any medicines containing aspirin in the last 4 weeks?
		Have you any anxieties or concerns about your forthcoming anaesthetics that you would like to discuss with your Anaesthetist?
		Have you / has your child ever had any allergic reaction to drugs (medicines, tablets, inhalers,) injections). Iodine, sticking plaster, food allergies etc? Please specify:
Medication Name / Food / Other:		Type of Reaction: