Southern Cross Healthcare

southerncrosshealthcare.co.nz

Forms To Fill Out

We need you to complete three pre-admission forms

We need you to complete these forms, to enable us to provide safe and personalised care to support your treatment and recovery.

One First, we need you to agree to receive treatment at our hospital.

Agreement to treatment
Completed and signed by you and your admitting doctor.

Two Next, we need your personal and payment or insurance details.

Patient admission form
Completed and signed by you (or parent/guardian).

Three We also need to know your current state of health and your medical and surgical history, and we need an up-to-date list of the medicines you are currently taking. This information, along with your personal needs and preferences, will allow us to tailor your care throughout your hospital stay.

Patient health questionnaire
Completed by you (or parent/guardian).

We need to receive your completed forms before your admission

To enable us to properly prepare for your admission, your hospital needs to receive all three completed forms **at least one week prior** to your admission.

You can hand deliver, post, photograph or scan (legibly) and email the forms*.

If you post the forms, please allow 1-2 extra weeks for delivery.

* The physical address, and email address of your hospital are listed on the back of **Your admission pack** folder. A Freepost envelope is also included in the pack.

PLEASE NOTE: Our website carries versions of Southern Cross hospital patient admission forms, some of which can be submitted electronically.

Please remember to bring any forms that you have not submitted electronically along with you. This includes the 'Agreement to Treatment' form, which may have been partially completed by your surgeon.

We protect your privacy

Any information and personal data gathered for the purpose of your visit to a Southern Cross hospital is to assist in your treatment, for quality assurance activities, and to fulfil legislative requirements. Your rights provided in the Health Information Code and Privacy Act 1993* will be respected, including your right to access and correct any information held about you. You can view our full privacy statement at https://healthcare.southerncross.co.nz/privacy-statement. If you have any concerns, please contact the general manager of the hospital†.

*More information can be found in the patient information compendium located in your hospital room or day stay area.

†The hospital general manager is the hospital's Privacy Officer.

Southern Cross Healthcare

Agreement To Treatment

IMPORTANT: Please send this completed form to the hospital where you will have your procedure/surgery.

THIS SECTION IS COMPLETED BY THE ADMITTING DOCTOR

Surname (family name): _____

First name (s): _____

Patient's date of birth: ____ / ____ / ____ (dd / mm / yyyy) Diagnosis: _____

Procedure/operation/treatment description: _____

_____

_____

_____

Operative side of body: Left / Right / Bilateral / Not applicable *(Please circle)*

Sedation: Yes ☐ No ☐ Anaesthesia: Yes ☐ No ☐ Proposed anaesthesia: general / local / regional / spinal / epidural *(Please circle)*

Admission details

Admission date: ____ / ____ / ____ (dd / mm / yyyy) Admission time: _____ Procedure/Surgery date: ____ / ____ / ____ (dd / mm / yyyy) *(If different to admission date)*

Day stay unit ☐ Day inpatient ☐ Overnight inpatient ☐ Anticipated length of stay _____ hours / days / nights

Hospital (where you will have your surgery/procedure): _____

Admitting doctor's instructions: _____

_____

_____

_____

_____

Admitting doctor's name: _____ Surgeon / Physician / General Practitioner *(Please circle)*

Admitting doctor's signature: _____ **Date:** ____ / ____ / ____ (dd / mm / yyyy)

(Where applicable please attach evidence of enduring power of attorney)

THIS SECTION IS COMPLETED BY THE PATIENT/GUARDIAN/ENDURING POWER OF ATTORNEY

I, _____ agree to have the procedure/operation/treatment described
(Patient's/Guardian's full name)

above performed on myself / my child _____ at _____
(Please circle) *(Name of patient, if patient not signing form)* *(Hospital where you will be having your procedure/surgery)*

I confirm that I have received a satisfactory explanation of the reasons for, risks and likely outcomes of the procedure/operation/treatment, and the possibility and nature of further related treatment including a return to theatre, should any complications arise.

I have had an opportunity to ask questions and understand that I may seek more information at any time and participate in decision making about my treatment.

I have been provided with sufficient information by my doctor in relation to the administration of blood components / blood products if necessary.
I *give* consent to the administration of blood or blood products if necessary: Yes ☐ No ☐

I understand that should a member of the healthcare team be directly exposed to my blood or other body fluids, I agree to blood samples being taken and tested. These samples will be tested only to identify such transmissible diseases as are considered of significant risk (e.g. Hepatitis and HIV). I understand I will be informed of the results if I request them, and any need for further medical referral. The results of these tests are confidential to me, the health professional(s) and the team member involved.

I give permission to Southern Cross Healthcare or any health professional (such as my medical specialist) involved in my care in relation to this admission to hospital, to access health information about me that is relevant to my treatment (including pre-admission and after discharge), which may be held by Southern Cross Healthcare, other health professionals or other health organisations.

Patient/Guardian signature: _____ Date: ____ / ____ / ____ (dd / mm / yyyy)

If not patient, state relationship to patient: _____

(Where applicable please attach evidence of enduring power of attorney)

Southern Cross Healthcare

Hospital Administration only
(Patient label)

ANAESTHESIA PLAN AND CONSENT

THIS SECTION IS COMPLETED WITH YOU BY THE ANAESTHETIST USUALLY ON THE DAY OF SURGERY

Proposed anaesthesia: General ☐ Local ☐ Regional ☐ Spinal/Epidural ☐ Sedation ☐
(Please tick)

Other: _____

Risk discussion

Sore Throat ☐ Nausea/Vomiting ☐ Dental Damage ☐ Allergic Reaction ☐ Itch ☐ Blood Clots ☐
Block Failure ☐ Nerve Damage ☐ Headache ☐ Hypotension ☐ Rare Serious Events ☐ Pain ☐ Bleeding ☐
ALL of the above discussed ☐

_____

_____

_____

Pain Relief Plan

Oral ☐ Intravenous ☐ PCA ☐ Epidural ☐ Spinal ☐ Wound Catheter ☐ PR ☐ Other ☐

Discussion notes: _____

_____

_____

_____

Anaesthetist's Instructions: _____

_____

_____

_____

Anaesthetist Statement

I have discussed the proposed anaesthetic plan and possible alternatives with the:

Patient ☐ Parent/Guardian ☐ Spouse/Partner ☐ Next-of-Kin ☐ EPOA ☐

Anaesthetist Name: _____ **Date:** ____ / ____ / ____
dd mm yyyy

Anaesthetist Signature: _____

THIS SECTION IS COMPLETED BY THE PATIENT/GUARDIAN/ENDURING POWER OF ATTORNEY

I, _____ agree to anaesthesia/sedation being given to
(Patient's/Guardian's full name)

myself /my child _____
(Please circle) *(Name of patient, if patient not signing form)*

I confirm that I have received a satisfactory explanation of the reasons for, risks and likely outcomes of the anaesthesia and I have had the opportunity to ask questions and understand I may seek more information at any time.

I understand the proposed anaesthesia may change as deemed necessary by the Anaesthetist.

I acknowledge that I should not drive a motor vehicle, operate machinery or potentially dangerous appliances, or make important decisions for 24 hours after having had the anaesthesia.

Patient/Guardian signature: _____ **Date:** ____ / ____ / ____
dd mm yyyy

If not patient, state relationship to patient: _____

(Where applicable, please attach evidence of enduring power of attorney)

Southern Cross Healthcare

Patient Admission Form

IMPORTANT: Please send this completed form to the hospital where you will have your procedure/surgery.

PERSONAL AND ADMINISTRATION DETAILS

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

First name(s): _____ **Preferred name:** _____

Date of birth: ____ /____ /____ (dd / mm / yyyy) **NHI:** _____

Gender: ☐ Male ☐ Female ☐ I identify my gender as _____

Residential address: _____

Postal address: _____

Email address: _____

Telephone: (Home) _____ (Business) _____ (Mobile) _____

New Zealand resident: Yes ☐ No ☐ *If No, complete the 'Acknowledgement Form: Non-NZ resident' (on our website).*

Which ethnic group do you belong to? *Tick the box or boxes which apply to you.*

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

☐ Other *(such as Dutch, Japanese, Tokelauan) Please state:* _____

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** ☐ **ACC** ☐ **DHB** ☐ **Paid personally** ☐ **Other** .....

Details of health insurance ☐ Southern Cross Affiliated Provider contract

Name of Insurer: _____

Insurance Plan Name: _____ Membership No: _____

Have you obtained "prior approval" for payment? Yes ☐ No ☐ Approval No: _____

Additional charges ***(Provide your prior approval letter in advance)***

Depending on your health insurance policy or plan you may be required to pay an excess (co-payment).
You may also be required to pay for some charges such as visitor meals that are not covered by insurance, ACC or DHB.

Payment prior to surgery

You may be asked to pay a deposit 3-5 days before admission. The amount is based on the estimated cost of the procedure payable by you not otherwise covered by your insurance, ACC or DHB. The deposit will be refunded to you if the procedure is cancelled.

Methods of payment

We accept payment by EFTPOS, VISA, Mastercard, internet banking or online at our website www.southerncrosshealthcare.co.nz (search "payment information"). Personal cheques are not accepted. We prefer not to receive payment by cash.

I will pay my account by: EFTPOS ☐ Credit Card ☐ Debit Card ☐ Internet Banking ☐

Internet banking details

Payee: Southern Cross Healthcare Ltd **Bank a/c:** 12-3113-0126623-00
Particulars: Patient Name **Code:** Date of Surgery e.g. 12 Sep 2020 **Reference:** Hospital e.g. Hamilton

Would you like to receive your invoice via email? ☐ YES ☐ NO

We will send the invoice to the email address you have provided above. If you wish it to go to another email address, please provide it here:

Email address (if different from the one provided above): _____

Please complete the agreement section on the reverse of this page.

Southern Cross Healthcare

IMPORTANT: Please send this completed form to the Hospital where you will have your procedure/surgery.

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.

I give permission for Southern Cross Healthcare 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 Southern Cross Healthcare. I accept that, in the event my hospital account is not met, Southern Cross Healthcare reserves the right to add all costs of collection to this account.

I give permission to Southern Cross Healthcare or any health professional (such as my medical specialist) involved in my care in relation to this admission to hospital, to access health information about me that is relevant to my treatment (including pre-admission and after discharge), which may be held by Southern Cross Healthcare, 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 Southern Cross Healthcare facilities are independent and not employees of Southern Cross Healthcare, with respect to both my treatment, care and account payment. I accept that this agreement is covered by New Zealand law. The details above have been completed by:

Name: _____ **Date:** _____
dd mm yyyy

Signature: _____ **If not the patient, state relationship to patient:** _____

Hospital (where you will have your surgery/procedure): _____

Please send your completed forms to the hospital where you have your surgery/procedure. If you do not yet have confirmation of the hospital where you will be admitted, please contact your specialist's practice to check the information required.

Southern Cross Healthcare

Patient Health Questionnaire

IMPORTANT: Please send this completed form to the hospital where you will have your procedure/surgery.
The hospital needs to receive all three forms at least one week prior to your admission. We also need any recent specialist letters. You can hand deliver, photograph or scan (legibly) and email, or post the forms. If you post the forms, please allow for 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):* _____

Hospital Administration only
(Patient label)

To support your ongoing care, your discharge information will be sent to your nominated GP. If you do NOT want this, please tick ☐

Surgeon _____

NHI *(if known)* _____

Your Occupation *(optional)* _____

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?

Q	Yes	No		If *Yes*
1	☐	☐	Difficulty climbing more than a flight of stairs	*What restricts this activity?*
2	☐	☐	Motion sickness	*mild / moderate / severe (circle one)*
3	☐	☐	Jaw problems *(difficulty opening mouth)*	*Specify:*
4	☐	☐	Problems with a previous anaesthetic	*Specify:*
5	☐	☐	Family history of problems with an anaesthetic	*Specify:*
6	☐	☐	Pacemaker or heart valve replacement	*Specify:*
7	☐	☐	Joint implants	*Specify:*
8	☐	☐	Other implant or prostheses and metalware	*Specify:*
9	☐	☐	Substance use or dependency	*Specify:*
10	☐	☐	Former smoker	*When did you quit?*
11	☐	☐	Currently on smoking cessation treatment	*Specify:*
12	☐	☐	Current smoker	*How many per day?*
13	☐	☐	Vaping	*How many times per day?*
14	☐	☐	Pregnant or possibly pregnant	*Approximate due date:*
15	☐	☐	Breastfeeding	
16	☐	☐	MedicAlert bracelet or necklace wearer	*Specify:*

Surname *(family name)*

First name *(s)*

Hospital Administration only
(Patient label)

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.

Q	Yes	No	
17	☐	☐	**Breathing conditions:** asthma | wheeziness | shortness of breath | bronchitis | croup | emphysema | COPD
18	☐	☐	**Sleeping conditions:** sleeplessness | severe snoring | obstructive sleep apnoea | CPAP used
19	☐	☐	**Heart conditions:** palpitations | irregular heart beat | heart murmur | angina | heart attack | chest pain congestive heart failure | rheumatic fever
20	☐	☐	**Stroke or Transient Ischaemic Attack (TIA)**
21	☐	☐	**High blood pressure or blood pressure controlled with medication**
22	☐	☐	**Blood clots:** deep vein thrombosis (DVT) | pulmonary embolus (PE)
23	☐	☐	**Family history of blood clots**
24	☐	☐	**Blood or bleeding conditions:** anaemic | bruising
25	☐	☐	**Family history of blood or bleeding conditions**
26	☐	☐	**Stomach and digestive conditions:** indigestion | heartburn | acid reflux | hiatus hernia | peptic ulcer
27	☐	☐	**Bowel conditions:** irritable bowel syndrome | constipation | bowel disease
28	☐	☐	**Liver disease:** jaundice | hepatitis
29	☐	☐	**Kidney conditions**
30	☐	☐	**Diabetes:** type 1 | type 2 | requiring insulin | requiring tablets | diet controlled
31	☐	☐	**Thyroid conditions**
32	☐	☐	**Parkinson's disease**
33	☐	☐	**Epilepsy, seizures, blackouts or fainting**
34	☐	☐	**Migraines or severe headaches**
35	☐	☐	**Alzheimers or dementia**
36	☐	☐	**Mental function conditions:** head injury | concussion | confusion or disorientation
37	☐	☐	**Mental health conditions**
38	☐	☐	**Emotional conditions:** anxiety | phobia | post traumatic stress disorder (PTSD)
39	☐	☐	**Arthritis:** osteoarthritis | rheumatoid | other
40	☐	☐	**Neck or back conditions**
41	☐	☐	**Gum or dental health conditions**
42	☐	☐	**Tuberculosis (TB)**
43	☐	☐	**HIV or AIDS**
44	☐	☐	**Infection or treatment for resistant organisms:** MRSA | ESBL | VRE | OTHER
45	☐	☐	**Cancer** *If **Yes,** please specify and provide details of any recent treatment in the Comments box below*
46	☐	☐	**Other condition(s) not listed above** *If **Yes,** please specify in the Comments box below*

RE QUESTION	YOUR COMMENT
21	*GP says my blood pressure is slightly high, but am not taking any medicine.*
	----Example----

Need more space for your comments? Please continue on a separate sheet and attach it to this page.

Surname *(family name)*

First name *(s)*

Hospital Administration only
(Patient label)

Section B In Preparation For Your Hospital Admission

B1. YOUR ALLERGIES, SENSITIVITIES, OR INTOLERANCES

Q	Yes	No	
47	☐	☐	Are you **allergic to latex?**
48	☐	☐	Do you have **any other allergies, sensitivities or intolerances?** *If **Yes,** please specify and describe the reaction using the box below*

	Item	Reaction
Skin-related	*Plasters* *----Example----*	*Rash* *----Example----*
Medicine-related		
Food-related		
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.*

Q	Yes	No		*If **Yes***
49	☐	☐	Do you have a **disability?**	*Specify:*
50	☐	☐	Do you have **difficulty understanding English?**	*Your preferred language:*
51	☐	☐	Do you have any **religious or spiritual needs** you would like us to know about?	*Specify:*
52	☐	☐	Do you have any **cultural or family needs** you would like us to know about?	*Specify:*
53	☐	☐	Do you have any **other special needs** you would like us to know about?	*Specify:*
54	☐	☐	If your procedure requires the **removal of body parts,** would you like them returned to you if this is possible?	
55	☐	☐	Do you have any **dietary requirements?**	☐ *vegetarian* ☐ *vegan* ☐ *diabetic* ☐ *gluten free* ☐ *halal* ☐ *dairy free* ☐ *bottle fed* ☐ *breast fed* ☐ *other* _____
56	☐	☐	Do you have any **specific food dislikes?** *For allergies or intolerances, refer to question **48***	*Specify*

Surname *(family name)*

First name *(s)*

Hospital Administration only
(Patient label)

Section C In Preparation For Your Procedure

C1. MEDICAL PROCEDURE HISTORY

Height _____ metres **Weight** _____ kilograms

Q	Yes	No	
57	☐	☐	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 or event	Year	Hospital

C2. ANAESTHESIA CONSIDERATIONS

Q	Yes	No		
58	☐	☐	Have you had an **anaesthetic** before?	☐ *general* ☐ *spinal* ☐ *epidural* ☐ *unsure*
59	☐	☐	Do you have any of these **dental features?**	☐ *upper denture* ☐ *lower denture* ☐ *crown(s) / cap(s)* ☐ *partial plate* ☐ *loose or chipped teeth*
60	☐	☐	Do you **drink alcohol**?	*How much?* _____

C3. PERSONAL ITEMS

Do you use any of these personal items?

Q	Yes	No		*If **Yes**, use this space to provide details, if needed*
61	☐	☐	Mobility aids such as a walking stick or cane?	
62	☐	☐	Glasses or contact lenses	
63	☐	☐	Hearing aids	

C4. BLOOD CLOT AND INFECTION CONSIDERATIONS

Q	Yes	No	
64	☐	☐	Have you completed the pre-admission risk assessment in the **Blood Clots and YOU** brochure?
65	☐	☐	Have you recently been on a **long distance flight?** *If **Yes**, when?* _____
66	☐	☐	If your operation is within the next 3 days: Have you had, or been in contact with anyone who has had **vomiting or diarrhoea?**
67	☐	☐	If your operation is within the next 7 days: Have you experienced **flu-like symptoms**, or been in contact with anyone diagnosed with **influenza?**
68	☐	☐	If your operation is within the next 4 weeks: Have you had a **head cold, throat or chest infection, or bronchitis?**
69	☐	☐	In the past 12 months, have you **travelled overseas?** *If **Yes**, please specify the country:* _____
70	☐	☐	In the past 12 months, have you been a patient or employee in a hospital or rest home in **New Zealand or overseas?** *If **Yes**, please specify the country:* _____
71	☐	☐	Do you have any **boils, cuts, sores, scratches or other skin infections?** *If **Yes**, specify:* _____
72	☐	☐	Do you have (or have you recently had) a **urine infection?** *If **Yes**, specify:* _____

C5. OTHER CONCERNS

Q	Yes	No		
73	☐	☐	Is there anything we need to know that you prefer not to write on this questionnaire? *If **Yes**, please discuss with your nurse or medical specialist when you arrive at the hospital*	
74	☐	☐	Do you have anxieties, concerns, or questions you wish to discuss before your procedure? *If **Yes**, who would you like to speak with?*	☐ *your surgeon* ☐ *your anaesthetist* ☐ *a nurse* ☐ *one of our admin. staff*

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 doctor 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. If you are taking any **blood thinning medication or supplements**, check with your surgeon if these need to be stopped prior to your admission .
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	*vitamins*	*tablets*	*patches*	*heart disease*	*infections*
herbal medicines	*supplements*	*capsules*	*suppositories*	*high blood pressure*	*diabetes*
natural medicines	*contraceptives*	*inhalers*	*creams*	*blood thinning*	*sleeplessness*
homeopathic medicines	*steroids*	*drops*	*injections*	*dietary deficiencies*	*epilepsy*
over-the-counter medicines		*syrups*	*other liquids*	*emotional conditions*	

D1. YOUR CURRENT MEDICINES			**HOSPITAL USE ONLY**					
Patient to complete - list all medicines you currently use.			**Reconciled:** Yes (✓) | No (x) | Not available (**NA**)					
Name of medicine *----Example----*	**Strength**	**How much you use, and when**	*Medicine container*	*Medication card*	*Patient or whānau/ family*	*Other (state) eg, 'phoned GP'*	Comment if No	ON ADMISSION: *Date/time last taken*
Paracetomol	*500mg*	*2 capsules every 6 hours*	-	-	-	-	-	-

If required, please continue on the reverse

This is not a prescription or an instruction to administer medicines

Surname *(family name)* **First name** *(s)*

Hospital Administration only
(Patient label)

Section D Your Current Medicines *(continues)*

Continued from reverse.

D1. YOUR CURRENT MEDICINES			HOSPITAL USE ONLY					
Patient to complete - list all medicines you currently use.			**Reconciled:** Yes (✓) | No (x) | Not available (**NA**)					
Name of medicine	**Strength**	**How much you use, and when**	*Medicine container*	*Medication card*	*Patient or whānau/ family*	*Other (state) eg, 'phoned GP'*	*Comment if No*	*ON ADMISSION: Date/time last taken*

This is not a prescription or an instruction to administer medicines