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PLEASE DETACH AND SEND TO MERCY HOSPITAL. IF FAXING OR SCANNING SEND BOTH SIDES.

PATIENT REGISTRATION FORM

MercyAscot
GREENLANE + EPSOM + TAKAPUNA

PLEASE RETURN THIS FORM **AT LEAST ONE WEEK** PRIOR TO YOUR OPERATION/PROCEDURE DATE

YOUR DETAILS

Title (please circle): Mr Mrs Ms Miss Dr Other

Gender: Male ☐ Female ☐

First Name(s):

Date of Birth: / /

Family Name:

Marital Status:

Previous Name:

Occupation:

Country of Birth:

NZ Resident: Yes ☐ No ☐

NHI No: (if known)

Residential Address:

Postal Address (if different from above):

Phone: Home ( ) Work ( ) Mobile ( )

Email:

Ethnic Group:

Language Spoken:

Interpreter Required: Yes ☐ No ☐

Interpreter services must be arranged through your surgeon's rooms prior to admission

If visiting from overseas what is your address while staying in NZ?

Phone: ( )

EMERGENCY CONTACT PERSON

Name:

Gender: Male ☐ Female ☐

Relationship to Patient:

Residential Address:

Phone: Home ( ) Work ( ) Mobile ( )

HEALTH INSURER

Name of Insurer:

Policy Type:

Membership No:

Prior Approval No:

Is your surgery covered by ACC: Yes ☐ No ☐

ACC Approval Granted: Yes ☐ No ☐

ACC Claim No:

ACC Office:

ACC Case Manager:

FAMILY DOCTOR

Name:

Address:

Phone: ( )

SURGEON/SPECIALIST

Name: Mr Adam Bartlett

Date of Admission: / /

Time of Admission:

PRESCRIPTION CARDS

☐ High Use Health Card Expiry Date: /

☐ Community Services Card Expiry Date: /

☐ Prescription Subsidy Card Expiry Date: /

☐ Other Expiry Date: /

1 of 2 – continue next page

PATIENT REGISTRATION FORM

MercyAscot
GREENLANE + EPSOM + TAKAPUNA

ACCOMMODATION

☐ Single Room with Ensuite ☐ Share Room ☐ Ward Room

- Please indicate your room preference as above
- Room choice is not applicable to patients covered by ACC
- Every effort will be made to accommodate your preference, but your choice may not be available or appropriate to your clinical needs
- You will be charged the rate for the actual room allocated, regardless of your preference

ACC CLAIMS

Contract Claim:
If your medical operation/procedure is an ACC Contract Claim, ACC will pay the hospital directly for all hospital and specialist's costs excluding personal expenses. Personal expenses, such as toll calls, drinks trolley beverages and visitor meals are required to be paid for on discharge.

Individual Claim:
If your medical operation/procedure is an individual ACC Claim, a copy of the ACC Letter of Approval **must** be received by Customer Support prior to Admission. **ACC does not cover full costs of hospitalisation.** A payment will be required on admission for the estimated difference.

Part ACC/Part Insurance:
Proof of prior approval is required on admission for the portion of your procedure that is covered by insurance. If you are not insured, you will be required to pay a portion of the estimated hospital costs on admission. For further details on ACC reimbursement practices please ask your ACC case manager.

PAYMENT OF HOSPITAL COSTS

For further information please refer to the Patient Information booklet

Payment will be made by ☐ credit card ☐ bank cheque ☐ cash ☐ EFTPOS ☐ other*

* Personal cheques are accepted by prior arrangement only. Personal cheques must be deposited **five** clear working days prior to admission to the hospital to allow for clearance.

- If you have no insurance, you will be required on admission, to pay the full estimated cost of the operation/procedure
- We strongly recommend you contact our Customer Support Team 09 623 5700 for an estimate of the hospital costs prior to admission
- You understand and give consent that relevant information may be supplied to an external credit reporting agency to obtain a credit report
- You agree you are responsible and will pay for all costs incurred in connection with your treatment
- You understand that MercyAscot may notify a credit reporting agency and/or instruct a debt collection agency should you default on any payment due by you to MercyAscot
- You understand that any collection and/or legal costs incurred in recovering any debt will be charged to you

PERSONAL PROPERTY

- You understand and agree that MercyAscot is not and will not be responsible for loss of or damage to any personal property (including jewellery, dentures, watches, rings, glasses) which you may bring into the hospital
- You consent to MercyAscot sharing relevant information that is related to your healthcare and as required by third parties such as Health Insurers, Medical Specialists, ACC, and for quality and audit purposes

To the best of your knowledge the information you have supplied to MercyAscot is correct.

Signature: _____

Print Name (in full:) _____ Date: ___ / ___ / ___

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PATIENT HEALTH QUESTIONNAIRE

MercyAscot
GREENLANE + EPSOM + TAKAPUNA

PLEASE RETURN THIS FORM **AT LEAST ONE WEEK** PRIOR TO YOUR OPERATION/PROCEDURE DATE

Dear Patient

The information requested in this form will help us assess your needs and plan your care for your booked admission to MercyAscot. All information will be treated in strict confidence.

When answering the questions, please do not write 'see my notes' or words to that affect because we do not have your clinical notes. Please answer as accurately as possible.

Please answer **all questions** on each page even if you think they are irrelevant to your circumstances.

Please bring any relevant X-rays/CT/MRI scans (CD discs) with you, along with any mobility aids, CPAP machines etc., to the hospital. If you develop any coughs, colds, infections or wounds before your admission, contact the hospital on 09 623 5700.

We look forward to helping you prepare for your operation/procedure.

Regards,
Admissions Unit Nurses

YOUR DETAILS

Full Name: Date of Birth: / /

Planned Procedure:

Home Phone Number: ( ) Mobile Number: ( )

NHI No: (if known) Date of Surgery: / /

FOR HOSPITAL USE ONLY

Pre-Admission Review:

Action Taken: Date: / /

Date unable to contact (1st Attempt): / /

Date unable to contact (2nd Attempt): / /

Investigations required (please review any existing results)

FBC ☐ Renal ☐ Coag ☐ G+H ☐ LFT ☐ INR ☐ CXR ☐ MDRO swabs ☐ ECG ☐ ECHO ☐

Other tests (specify):

Name: Designation:

Signature:

1 of 4 – continue next page

PATIENT HEALTH QUESTIONNAIRE

MercyAscot
GREENLANE + EPSOM + TAKAPUNA

DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? If yes, please give details below

	Yes	No
High Blood Pressure	☐	☐
Heart Attack	☐	☐
Heart Murmurs	☐	☐
Artificial Heart Valve	☐	☐
Chest Pains/Angina	☐	☐
Coronary Angiogram or Stents	☐	☐
Rheumatic Fever	☐	☐
AF/Palpitations/Arrhythmias	☐	☐
Ischaemic Heart Disease	☐	☐
CORD (Chronic Obstructive Respiratory Disease)	☐	☐
Asthma	☐	☐
Emphysema/Bronchitis	☐	☐
Persistent Cough	☐	☐
Shortness of Breath	☐	☐
Obstructive Sleep Apnoea	☐	☐
Does lying flat make you breathless?	☐	☐
Stroke/CVA/TIA	☐	☐
Anaemia/Bleeding Disorders	☐	☐
Blood Clots	☐	☐
Epilepsy/Seizure	☐	☐
Blackouts/Fainting	☐	☐

	Yes	No
Heartburn/Reflux	☐	☐
Diabetes	☐	☐
Diet controlled	☐	
Tablet controlled	☐	
Insulin controlled	☐	
Renal/Kidney Disease	☐	☐
Hepatitis A ☐ B ☐ C ☐	☐	☐
HIV/AIDS	☐	☐
Tuberculosis	☐	☐
Have you or a blood relative ever had any problems during or after anaesthesia?	☐	☐
Problems opening your mouth or with neck stiffness?	☐	☐
Malignant Hyperthermia	☐	☐
Taken Human Growth Hormones prior to '92	☐	☐
Brain or spinal surgery which included the use of a dura mater graft?	☐	☐
Are you or could you be pregnant?	☐	☐
Have you suffered motion sickness or post-op nausea and vomiting?	☐	☐
History of Cancer?	☐	☐

	Yes	No
Pacemaker	☐	☐
Joint Implants or Metalware	☐	☐
Arthritis	☐	☐
Mobility: Use Equipment (e.g. crutches/frame)	☐	☐
Completely Dependant	☐	☐
History of Falls	☐	☐
Is activity restricted by: Shortness of Breath?	☐	☐
Joint Pain?	☐	☐
Muscle Pain?	☐	☐
Current Skin Problems (e.g. ulcers, wounds, eczema, boils)	☐	☐
Wear glasses/contact lenses	☐	☐
Other vision impairments?	☐	☐
Hearing difficulties	☐	☐
Do you or have you ever smoked?	☐	☐
If 'yes', how much?		
If 'yes', for how long?		
When did you give up?		
Do you drink alcohol?	☐	☐
If yes, how many units **weekly** (Units/Weekly)		
(1 standard glass wine or ½ glass beer = 1 unit)		
Recreational Drugs	☐	☐
Special Dietary Requirements	☐	☐

If you answered 'yes' to any of the questions above then please give details, including treatment. **If you require more space, attach an additional sheet.**

Do you have any other medical conditions not already covered, or is there anything else we should know about you e.g. Parkinson's, mental illness, Alzheimer's, muscle/nerve disease? Yes ☐ No ☐

If 'yes' please give details:

Do you have any religious beliefs/practices or cultural needs we should be aware of? Yes ☐ No ☐

If 'yes' please give details:

If you have a body part removed during surgery, would you like it returned to you? Yes ☐ No ☐

Are you waiting to see (or have recently seen) your doctor or hospital specialist about a health condition unrelated to the proposed operation/procedure you are currently being assessed for? Yes ☐ No ☐

If 'yes' please give details:

2 of 4 – continue next page

To be filed in the Clinical Record behind Registration Form

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PATIENT HEALTH QUESTIONNAIRE

MercyAscot
GREENLANE + EPSOM + TAKAPUNA

Full Name:

Have you lived or worked overseas in the six months prior to your admission? Yes ☐ No ☐

Have you ever had MRSA , ESBL or VRE infection? Yes ☐ No ☐

Have you been in a hospital in NZ, including MercyAscot, or overseas **within the last six months**? Yes ☐ No ☐

Do you work in a health care facility? Yes ☐ No ☐

Height m Weight kg

This information is important. **Do not leave this blank.** If you do not know, an estimate is acceptable.

Are you allergic/sensitive to any:	Yes	No	If 'yes' please name the items and describe reaction:
Medications	☐	☐	
Foods	☐	☐	
Latex	☐	☐	
Plasters/tape/skin preparations (e.g. iodine, chlorhexidine)	☐	☐	
Other	☐	☐	

Please list **all** previous admissions to hospital for operations/procedures and/or medical reasons. Please include where and when. **(Estimate if unsure)**. **If you require more space, attach an additional sheet**.

Reason for admission	Hospital	Month/Year

Please list **all** medicines – tablets, inhalers, patches etc. prescribed by your doctor or **over the counter** (include any herbal or natural remedies or dietary supplements). **If you require more space, attach an additional sheet**.

Name of Drug	Strength	Dose	Frequency

Does anyone assist you with administration of your own medication? Yes ☐ No ☐

If 'yes' please give details:

Is your medication packed in "compliance" (blister) packaging? Yes ☐ No ☐

PLEASE BRING ALL YOUR MEDICATIONS, IN ORIGINAL PACKETS, WITH YOU TO HOSPITAL.

3 of 4 – continue next page

DISCHARGE PLANNING

Being prepared for your discharge is just as important as being prepared for your admission. As part of your discharge plan we will anticipate the day of discharge prior to your arrival at the hospital. This will help relieve your anxiety and prepare you for your discharge home.

You will need someone to stay with you for at least 24 hours after discharge. This may be longer depending on your surgery.

Please complete the section below so we can see what care and support you will need to ensure a safe and speedy recovery.

CARER SUPPORT:

Current living arrangements? Tick one.

☐ Live alone ☐ Live with others i.e. partner/children

☐ Have caring responsibilities for others at home. Please specify:

If you are the sole caregiver for a dependant, you will need to consider making arrangements for their care during your hospital stay and up to five days after your discharge or as advised by your surgeon.

Who will be caring for **you** following your discharge?:

Name: Relationship:

Address:

Phone Number (mobile/landline):

FORMAL SUPPORTS:

Do you currently receive any formal supports (i.e. home help, meals on wheels)? Yes ☐ No ☐

If 'yes', please state who, and for how many hours per week.

You will need to notify your formal supports of your hospital admission date and proposed discharge date.

If you think that you will require respite care for a period of time after discharge, please discuss this with your surgeon. You may be responsible for any costs associated with this arrangement. These arrangements should be organised by you prior to your admission.

DISCHARGE/TRANSPORT:

Please advise the person collecting you that the discharge time is **10am**.

Name: Contact Phone Number (mobile/landline):

Please feel free to add any further comments/concerns regarding discharge:

It is important to know **who** has **completed this form**. Please **print and sign your name**.

Print Name (in full:) Date: / /

Signature:

I am the ☐ patient ☐ legal guardian ☐ parent ☐ other (specify)

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CONSENT FOR OPERATION/PROCEDURE

MercyAscot
GREENLANE + EPSOM + TAKAPUNA

PLEASE DETACH AND SEND TO MERCY HOSPITAL

PATIENT DETAILS

Patient Name: _____ Date of Birth: / /

Date of Admission: / / Time: _____

Referring Consultant: _____

ACC Contract ☐ ACC Non-Contract Surgeon Lead Provider ☐ Surgeon Contract, Non-Contract MercyAscot Lead Provider ☐

CONSULTANT TO COMPLETE

Diagnosis: _____

Planned Operation/Procedure: _____

_____

_____

Proposed Date of Surgery: / / Operation Length: _____ Length of Stay: _____

Body Side: Left ☐ Right ☐ Inpatient: ☐ Day Case: ☐

I have explained to _____ the benefits and risks of the above planned operation/procedure.

_____

_____

Surgeon's Name: Mr Adam Bartlett Signature: _____ Date: / /

PATIENT TO COMPLETE

I agree that I have received a reasonable explanation of the intent, alternatives, risks and likely outcomes of the operation/procedure of _____ (brief procedure description) to the _____ (left/right) side of my body. In the event that something unexpected is found during surgery, I authorise the surgeon to act in my best interest.

I agree to the collecting of personal and health information from myself or my representative and authorise use of this information for purposes related to my health care.

In the event of a staff member receiving a 'needle stick injury' or other 'blood accident' from instrumentation used during my operation/procedure, I consent to a blood sample being drawn from myself and tested for HIV (the AIDS virus), Hepatitis B, Hepatitis C and any other blood test deemed necessary by my doctor. I understand I will be informed of such testing and the results if I request them.

Patient/Guardian Signature: (Please circle one) _____ Date: / /

STAT MEDICATION ORDERS ON ADMISSION

Date	Drug	Dose	Route	Time	Authorised By	Given By	Time

Other preparations required (e.g. TEDs/SCDs), please specify: _____

INVESTIGATION REQUIRED

Please tick either: A = Prior to Admission, B = On Admission, C = Not Required

	A	B	C		A	B	C		A	B	C		
Electrolytes	☐	☐	☐	Coag Screen	☐	☐	☐	MSU	☐	☐	☐	Ordered at Labtests	☐
Routine Haematology	☐	☐	☐	Group & Ab Screen	☐	☐	☐	ECG	☐	☐	☐	Ordered at other lab	☐
Urea & Creatinine	☐	☐	☐	Cross match ____ units	☐	☐	☐						
(Other) _____	☐	☐	☐	(Other) _____	☐	☐	☐	X-rays (state)					

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