GILLIES HOSPITAL

A Surgical Group Ltd & Southern Cross Hospitals Partnership

FORMS TO FILL OUT

Please ensure all sections are completed fully so that we are able to meet your individual needs and deliver our promise of quality care.

Please return your 3 completed forms to Gillies Hospital as soon as possible, ensuring that they arrive **one week** before your admission.

These can be either posted, faxed (09 631-1901), or emailed to: bookings@gillieshospital.co.nz or hand delivered to the hospital. If faxing or emailing, please bring original forms on admission.

Checklist

Before coming into Hospital, have you …

- ☐ Completed and returned your 3 forms to the Hospital
- ☐ Contacted your insurance company for "prior approval"
- ☐ Arranged transport to and from the Hospital
- ☐ Completed any special preparations

Remember to bring your …

- ☐ Patient information pack
- ☐ Insurance "prior approval" letter
- ☐ Anaesthetic Information Leaflet
- ☐ Current medications
- ☐ X-rays, scans or test results
- ☐ Doctor(s) letters
- ☐ Glasses/hearing aid

Privacy

Any information and personal data gathered for the purpose of your visit to Gillies Hospital is to assist in your treatment, for quality assurance activities and to fulfil legislative requirements. Your rights provided in the Health Information Privacy Code and the Privacy Act 1993 will be respected including your right to access and if necessary, correct any information held about you. If you have any concerns, please contact the Hospital Manager who is the Privacy Officer.

More information on the Health Information Privacy Code and the Privacy Act 1993 can be found at http://www.privacy.org.nz/health-information-privacy-code/

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AGREEMENT TO TREATMENT

Please ensure that this form is returned to Gillies Hospital as soon as possible, and at least one week before admission.

THIS SECTION IS COMPLETED BY THE SURGEON

Surname (family name): ______________________ First name: ______________________

Patient's date of birth: ______ / _____ / ______
d m y

Procedure/operation/treatment description: ______________________

____

____

____

____

Anaesthesia: Yes ☐ No ☐ Proposed anaesthesia: general / local / regional / spinal / epidural / LAS
(please circle)

Admission details

Operation date: ______________________ ☐ Day stay patient ☐ Overnight stay ☐ No. of nights

Interpreter required Yes ☐ No ☐ (Hospital to Organise)

Surgeon's instructions: ______________________

____

Surgeon's name: ______________________

THIS SECTION IS COMPLETED BY THE PATIENT/GUARDIAN WITH YOUR SURGEON

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

above performed on 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 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 agree to the administration of blood or blood products that may be required.

I agree to procedural images being taken as required, and to be held by my surgeon.

I agree to local anaesthesia/sedation. (as appropriate)

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 Gillies Hospital or any 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 Gillies Hospital, other health professionals or other health organisations.

Patient/Guardian signature: ______________________ **Date:** ______ **/** _____ **/** _____
d m y

If not patient, state relationship to patient: ______________________
(Please provide evidence of enduring power of attorney if appropriate).

Surgeon's signature: ______________________ **Date:** ______ **/** _____ **/** _____
d m y

Hospital use only: Received: ______ **/** ______ **/** ______ **RN** ________

Hospital Administration only
(Please insert patient label)

AGREEMENT TO ANAESTHESIA

THIS SECTION IS COMPLETED WITH YOUR ANAESTHETIST ON DAY OF SURGERY

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

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:** ______ / ______ / ______
d m y

If not patient, state relationship to patient: ______________________________
(Please provide evidence of enduring power of attorney, if applicable).

Anaesthetist's name: ______________________________

Anaesthetist's signature: ______________________________ **Date:** ______ / ______ / ______
d m y

Anaesthetist's instructions: ______________________________

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PATIENT ADMISSION FORM

Please ensure that this form is returned to Gillies Hospital as soon as possible, and at least **one week** *before admission.*

PERSONAL AND ADMINISTRATION DETAILS

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

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

Date of birth: ___ / ___ / ___ (d m y) **Gender:** Male ☐ Female ☐ **NHI:** ______

Residential address: ______

Postal address: ______

Email address: ______

Telephone: (Home) ______ (work) ______ (Mobile) ______

New Zealand resident: Yes ☐ No ☐

Ethnicity: European / Maori / Pacific Island / Asian / Middle Eastern / Latin American / African / Other ______
(Please circle one or more)

General Practitioner: ______ **Telephone:** ______

Surgeon: ______

NEXT OF KIN/CONTACT PERSON

Name: ______ **Relationship to patient:** ______

Address: ______

Telephone: (Home) ______ (work) ______ (Mobile) ______

PAYMENT DETAILS

How will your procedure be paid for? Tick and complete as many as applies:

☐ **Health insurance** (personal expenses such as telephone calls may be excluded)

Name of Insurer: ______ Policy No: ______

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

Affiliated provider contract ☐

☐ **Contract: e.g. ACC / DHB / Cochlear** (personal expenses such as telephone calls are excluded)

☐ **Paid personally** If you are paying for the procedure yourself, please note that some procedures may require a deposit before admission. Gillies Hospital may inform you if a deposit applies.

ACCOUNT SETTLEMENT AND CREDIT CARD AUTHORISATION

I will pay my account by: Cheque ☐ Cash ☐ Credit card ☐ Eftpos ☐ (daily limits may apply)

If you select credit card as your payment option, please complete and sign:

Card type: MasterCard ☐ Visa ☐ Diners ☐ AMEX ☐

Credit card number: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ Expiry date: ___ / ___ (m y)

Name on credit card: ______ Signature: ______

I understand that signing this Credit Card Authority authorises Gillies Hospital to debit my credit card with all amounts due and owing to Gillies Hospital in relation to my admission and treatment at Gillies Hospital.

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 Gillies Hospital 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 Gillies Hospital. I accept that, in the event my Hospital account is not met, Gillies Hospital reserves the right to add all costs of collection to this account. I understand the admitting Surgeon, Anaesthetist and other Doctors or health professionals using Gillies Hospital facilities are independent and not employees of Gillies Hospital, 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: ___ / ___ / ___ (d m y)

Signature: ______

If not the patient, state relationship to patient: ______

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PAEDIATRIC HEALTH QUESTIONNAIRE

FOR CHILDREN 12 YEARS OR YOUNGER

Please ensure that this form is returned to Gillies Hospital as soon as possible, and at least **one week** *before admission.*

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

Date of birth: ____/____/____ (d m y) **Telephone / Contact:** ______________________

It is important that you answer ALL the questions as accurately as possible. All information is sought to minimise your child's risk and will be retained as part of their confidential clinical records.

PLEASE FILL IN THE FOLLOWING:

Child's weight: __________ kg

Child's height: __________ cm

DOES YOUR CHILD HAVE ANY:

Yes No (Please tick **Yes** or **No**, Circle a word where appropriate.)

- ☐ ☐ Allergies to food, medicine, latex, plasters etc
- ☐ ☐ Asthma
- ☐ ☐ Cough, cold or chest infection, flu
- ☐ ☐ Breathing problems
- ☐ ☐ Kidney or urine problems
- ☐ ☐ Rheumatic fever or heart problems
- ☐ ☐ Other medical conditions
- ☐ ☐ Was your child born prematurely?
- ☐ ☐ Admitted to the Special Care Unit?

HAS YOUR CHILD HAD:

Yes No

- ☐ ☐ Previous operations
- ☐ ☐ Been in hospital for other reasons e.g. asthma
- ☐ ☐ Had problems with an anaesthetic
- ☐ ☐ Have family members had problems with anaesthesia
- ☐ ☐ Contact with Antibiotic resistant infectious organisms eg MRSA / VRE / ESBL / Other
- ☐ ☐ Seizures or fits
- ☐ ☐ Bleeding problems including family history
- ☐ ☐ Recent exposure to infectious diseases / anyone with vomiting and/or diarrhoea in the past 3 days

- ☐ ☐ Had a hospital admission in past 6 months (NZ/Overseas)? If Yes, where ______________________
- ☐ ☐ If the procedure requires the removal of any body parts, would you like them returned?

If you have answered YES to any of the above, please give further details below:

____

____

If your child is taking any medication, please list: drugs, tablets, inhalers, injections, herbal remedies, vitamins and other supplements:

____

____

Special needs:

Please state the details of any disability, physical or emotional, cultural, family, religious or spiritual needs, special privacy or any other requirements:

____

____

If you have any specific questions for the hospital, please outline:

____

____

Special dietary requirements: ☐ Standard ☐ Vegetarian ☐ Bottle/Breast fed Other: __________

____

DAY STAY PATIENTS:

Yes No

☐ ☐ Do you have access to a phone?

Contact phone number on discharge ______________________

How long does it take you to travel to your local hospital? __________

Signed ______________________ (Parent/Guardian) Date: __________

Parent's/Guardian's name: ______________________ (Please print)

If your child becomes ill after you have returned this form please contact your surgeon or Gillies Hospital.

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ADULT HEALTH QUESTIONNAIRE

Please ensure that this form is returned to Gillies Hospital as soon as possible, and at least **one week** *before admission.*

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

Date of birth: ______ /______ /______ (d m y) **Telephone / Contact:** ______________________

All questions in this questionnaire are about the person being treated at Gillies Hospital.

Have you ever had or does the patient currently have any of the following?

Yes No (Please tick **Yes** or **No**. Circle a word where appropriate.)

- ☐ ☐ Type I Diabetes – tablets / insulin
- ☐ ☐ Type II Diabetes – diet controlled / tablets / insulin
- ☐ ☐ High blood pressure / Swollen ankles
- ☐ ☐ Angina / Heart attack / Heart failure / Palpitations / Pacemaker
- ☐ ☐ Stroke / TIA (transient ischaemic attack)
- ☐ ☐ Epilepsy / Severe headaches / Blackouts
- ☐ ☐ Asthma / Wheeziness
- ☐ ☐ Emphysema / Bronchitis / Croup
- ☐ ☐ Obstructive sleep apnoea (intermittently stopping breathing during sleep)
- ☐ ☐ Tuberculosis / Rheumatic fever / Heart murmur
- ☐ ☐ Heartburn / Acid reflux / Hiatus hernia / Indigestion / Stomach or peptic ulcer
- ☐ ☐ Blood clots in legs or lung
- ☐ ☐ Bleeding problems / Anaemia / Bruising
- ☐ ☐ Family history of bleeding problems
- ☐ ☐ Arthritis – If yes, which joints?
- ☐ ☐ HIV / AIDS / risk of exposure to HIV
- ☐ ☐ Hepatitis A / B / C / Jaundice
- ☐ ☐ Are you a hepatitis carrier?

Yes No

- ☐ ☐ In the last 6 months have you been a patient or employee in a hospital/s in NZ or Overseas
  Name of hospital or country ______________
  Name of Ward: ______________
- ☐ ☐ Antibiotic resistant infectious organisms eg MRSA / VRE / ESBL / Other
- ☐ ☐ Have you had, or been in contact with anyone who has had, vomiting and/or diarrhoea in the past 3 days
- ☐ ☐ Recent cough, cold, flu
- ☐ ☐ Recent boils, skin or other infections
- ☐ ☐ Recent exposure to infectious diseases
- ☐ ☐ Substance dependency (e.g. drugs, alcohol)

DO YOU

- ☐ ☐ Smoke / Used to smoke? How many per day? ________
- ☐ ☐ Drink alcohol daily? If **YES** how much? ________
- ☐ ☐ Use recreational drugs?
- ☐ ☐ Wear dentures / partial plate / crowns / caps / loose teeth
- ☐ ☐ Wear contact lenses / glasses / hearing aid
- ☐ ☐ Have any implants / prosthesis / piercings
- ☐ ☐ Believe you are pregnant? If **YES** state months ________
- ☐ ☐ Suffer from motion sickness: mild / moderate / severe
- ☐ ☐ Have difficulty climbing more that one flight of stairs?
  If **YES**, what restricts this activity? ________

If YES to any above give details below:

____

____

____

List all current medicines, drugs, tablets, inhalers, injections, oral contraceptives, HRT, herbal remedies, vitamins, and other supplements:

Medications/Remedies/Supplements	Dose	Frequency	Hospital Use Only

Please bring a print out from your Pharmacy of your current medications and dosage, along with the medications in their original containers.

Patient Name: ____________________

Yes No

☐ ☐ Any other major illnesses or conditions?
If **YES,** please specify: (e.g. Kidney or liver problems, Thyroid disease, Malignant Hyperthermia).

☐ ☐ Have you ever had any **allergic reactions** to latex, iodine, medications, plasters, food or any other substance?
If **YES,** please list your **allergies** and describe the **reactions**:

☐ ☐ Have you had an anaesthetic before?
☐ ☐ Have problems opening mouth?
☐ ☐ Have you or any other family member had any problems with an anaesthetic?
If **YES,** please explain: ____________________

List all procedures/operations you have had (start with the most recent).

Procedures/Operations	Year	Hospital

Your weight: __________ Kgs Your Height: __________ cm BMI: __________ (Hospital Use Only)
(Essential for anaesthetic assessment)

Do you have any special needs? If YES, please provide more details.

Yes No

☐ ☐ Disability ____________________
☐ ☐ Physical support or aids ____________________
☐ ☐ Religious or spiritual needs ____________________
☐ ☐ Cultural or family/whanau needs ____________________
☐ ☐ Dietary requirements: Standard ☐ Diabetic ☐ Vegetarian ☐ Other ☐ ____________________
☐ ☐ Do you have anxieties, concerns, questions or additional matters you wish to discuss before your surgery with:
Surgeon ☐ Anaesthetist ☐ Nurse ☐ Administration ☐
☐ ☐ If your procedure requires the removal of any body parts, would you like them returned?

Day Stay Patients

Yes No

☐ ☐ Do you have someone to drive you home?
☐ ☐ Do you have access to a phone?
☐ ☐ Do you have a support person to be with you 24 hours post surgery?
How long does it take you to travel to your local hospital? ____________________
Contact phone number on discharge: ____________________