Southern Cross

Ormiston Hospital & Healthcare

Agreement to Treatment

THIS SECTION IS COMPLETED BY THE ADMITTING DOCTOR

First Name : _____ Last Name : _____

Date Of Birth : _____ /_____ /_____ Diagnosis : _____

Procedure/operation/treatment description : _____

_____

Risks discussed : _____

Operative side of body: Left ☐ Right ☐ Bilateral ☐ Not applicable ☐

Sedation: Yes ☐ No ☐ Anaesthesia: Yes ☐ No ☐ Proposed anaesthesia: general / local / regional / spinal / epidural

Admission details

Admission date: _____ Admission time: _____ Procedure/Surgery date: _____

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

Admitting doctor's instructions : _____

_____

Admitting doctor's name : _____ Surgeon / Physician / General Practitioner

Admitting doctor's signature : _____ Date : _____

(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 listed above 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 authorise Ormiston Surgical and Endoscopy Ltd (as well as any healthcare professionals involved in my care), to access relevant health information, related to my current treatment and any other necessary communications. This may include records or communications held by Ormiston, Southern Cross Healthcare, other healthcare professionals, or other healthcare organisations.

I consent to the use of photography or filming for teaching and training purposes ☐

Patient/Guardian signature: _____ Date: _____

If not patient, state relationship to patient: _____

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

Patient Admission Form

PERSONAL AND ADMINISTRATION DETAILS

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

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

Date of birth: _____ **NHI:** _____

Sex at birth: Male ☐ Female ☐ **Gender:** Male ☐ Female ☐ Gender diverse ☐ Non-binary ☐ Other ☐

Residential address: _____

Postal address: _____

Email address: _____

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

New Zealand resident: Yes ☐ No ☐

Ethnicity: European / Māori / Pacific Island / Asian / Middle Eastern / Latin American / African / Other: _____

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** (personal expenses such as telephone calls are excluded)

Name of Insurer: _____

Insurance Plan Name: _____ Membership Number: _____

Have you obtained "prior approval" for payment? YES ☐ NO ☐ Approval Number: _____

☐ **ACC** (personal expenses such as telephone calls are excluded) ☐ **DHB** (some personal expenses are excluded)

☐ **Paid Personally** - if you are paying for the procedure yourself, you may be asked to pay an estimated deposit 3-5 days before admission.

The balance of your account must be settled on discharge.

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

For Internet Banking:

Payee: Ormiston Surgical and Endoscopy | **Particulars**: Patient Name | **Bank a/c**: 02-0191-0522222-000 | **Reference**: Invoice Number

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. Estimates provided by surgical rooms are subject to change with potential cost variations relating to theatre time or resources.

I give permission for Ormiston 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 Ormiston Hospital. I accept that, in the event my Hospital account is not met, Ormiston Hospital reserves the right to all costs of collection to this account.

I give permission to Ormiston 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 Ormiston Hospital, 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 Ormiston Hospital facilities are independent and not employees of Ormiston Hospital, with respect to both my treatment, care and account payments.

I accept that this agreement is covered by New Zealand law. The details above have been completely by:

Name: _____ **Date:** _____

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

Patient Health Questionnaire

The hospital needs to receive these forms at least one week prior to your admission. You can hand deliver, fax, scan and email the forms.

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)

Height _____ metres _____

Weight _____ kilograms _____ Surgeon _____

Occupation (optional) _____ NHI (if known) _____

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: DO YOU HAVE ANY MEDICAL CONDITIONS?

TYPE OR DETAILS

Yes	No	Question	
☐	☐	Diabetes	Diet Control ☐ Tablets ☐ Insulin ☐
☐	☐	High Blood Pressure	
☐	☐	Arrythmias (irregular heart rate)/palpitations	
☐	☐	Pacemaker/Artificial Valve	Pacing ☐ Defibrillator ☐
☐	☐	Blood thinning medication	
☐	☐	Cardiac (Heart) Conditions	
☐	☐	Stroke/TIA (Transient ischemic attack)	
☐	☐	Epilepsy/Seizures	
☐	☐	Obstructive Sleep Apnoea	
☐	☐	Respiratory (Lung) Conditions (Asthma, COPD, SOB)	
☐	☐	Gastrointestinal conditions (GORD, IBS, IBD)	
☐	☐	Bleeding problems or blood clots/DVT	
☐	☐	Organ transplant/Immunosuppression	
☐	☐	Cancer treatment +/- chemotherapy or radiotherapy	
☐	☐	Motion Sickness	
☐	☐	Emotional conditions - anxiety, PTSD, phobia's	
☐	☐	Any other illness or condition we should be aware of (Liver or kidney disease, Parkinson's, dementia, Alzheimer's, malignant hypothermia, glaucoma, prostate problems...)	

If you have answered yes to any of the above, please provide details:

_____

_____

_____

Southern Cross
Ormiston
Hospital & Healthcare

Surname (family name)

First name (s)

Hospital Administration only
(Patient label)

A2: MEDICAL PROCEDURE HEALTH ALERTS

Yes	No	Question	If yes
☐	☐	Do you have any of these dental features?	upper denture / lower denture / crown(s) / cap(s) partial plate / loose or chipped teeth
☐	☐	Do you drink alcohol?	How much?
☐	☐	Substance use or dependency	Specify
☐	☐	Former smoker	When did you quit?
☐	☐	Current smoker	How many per day?
☐	☐	Medic alert bracelet or necklace wearer	Sepcify

SECTION B : IN PREPARATION FOR YOUR HOSPITAL ADMISSION

B1: YOUR ALLERGIES, SENSITIVITIES, OR INTOLERANCES

Yes	No	Question
☐	☐	Are you allergic to latex?
☐	☐	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		
Medicine-related		
Food-related		
Other		

Surname (family name)

_____

First name (s)

_____

Hospital Administration only
(Patient label)

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.

Yes	No	Question
☐	☐	Do you have a disability or need support with mobility?
☐	☐	Do you have difficulty understanding English? **Your preferred language:** _____
☐	☐	Do you have any religious or spiritual needs you would like us to know about?
☐	☐	Do you have any cultural or family needs you would like us to know about? (inlcuding Kaimahi services)
☐	☐	Do you have any other special needs you would like us to know about?
☐	☐	If your procedure requires the removal of body parts, would you like them returned to you if this is possible?

If you have answered yes to any of the above, please provide details:

_____

_____

_____

SECTION C : IN PREPARATION FOR YOUR PROCEDURE

C1: PERSONAL ITEMS

Do you use any of these personal items?

Yes	No	Question	If Yes, use this space to provide details, if needed
☐	☐	Mobility aids, such as a walking stick or cane	_____
☐	☐	Glasses or contact lenses	_____
☐	☐	Hearing aids	_____
☐	☐	Earrings or other piercing jewellery	_____

C2: BLOOD CLOT AND INFECTION CONSIDERATIONS

Yes	No	Question
☐	☐	In the past 3 days, have you had, or been in contact with anyone who has had, vomiting or diarrhoea?
☐	☐	In the past 7 days, have you experienced flu-like symptoms, or been in contact with anyone diagnosed with
☐	☐	influenza/Covid-19?
☐	☐	In the past 4 weeks, have you had a head cold, throat or chest infection, or bronchitis?
☐	☐	In the past 12 months, have you travelled overseas, or been a patient or employee in a hospital or rest home
☐	☐	in New Zealand or overseas? **If Yes, please specify where** _____
☐	☐	Do you have HIV or AIDS?
☐	☐	Do you have any multidrug-resistant organisms (MRSA, ESBL, VRE, CPE)?

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 doctors 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. To ensure you are clear what to include, please use the MEDICINE REMINDERS table
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, herbal medicines, natural medicines, homeopathic remedies, over-the-counter medicines, vitamins, supplements, contraceptives, steroids	tablets, capsules, inhalers, drops, syrups, patches, suppositories, creams, injections, other liquids	heart disease, high blood pressure, blood thinning, emotional conditions, infections, diabetes, sleeplessness, epilepsy

D1. YOUR CURRENT MEDICINES			HOSPITAL USE ONLY					
Patient to complete - list all medicines you currently use.			Reconciled: Yes (Y) | No (N) | 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
Example - Paracetamol	500mg	2 capsules every 6 hours	-	-	-	-	-	-