

Next of Kin / Contacts

1) Contact Person Relationship
 Address Number where staying whilst you are in hospital
 Phone Number Home Business Mobile

2) Contact Person Relationship
 Address Number where staying whilst you are in hospital
 Phone Number Home Business Mobile

Payment Details

Have your hospital costs been approved by:

Medical Insurance: Name of Company Policy Number
 Self
 ACC ACC Claim No. App No.
 ACC Injury Date. OP Code
 NDHB

I agree that I am responsible and will pay for all costs incurred in connection with my treatment, that are not covered by other parties (ie ACC, Medical Insurance). Overdue accounts will incur debt collection fees.

Are you on Weekly Compensation from ACC? YES NO

Health Information Privacy Explanation

Under the provisions of the Health Information Privacy Code 1994 there is a requirement to collect and store information about each patient to help provide good and safe treatment. It is mandatory to send certain health information to other organisations such as the Ministry of Health. Your medical records will be kept secure and will only be accessed by authorised personnel. You as a patient, have the right of access to your notes for as long as Kensington Hospital stores them. During this time, if you desire, you can update or correct your medical notes. Requests for access to your notes should be made through our Privacy Officer.

On the day of your operation until you are able to receive phone calls, our reception or nursing staff will provide callers with a general statement regarding your health, unless advised otherwise.

If you do not wish to have any information disclosed about your stay - please inform us on admission.

If for any reason you require to be transferred to another hospital a copy of your notes from Kensington Hospital will accompany you. A copy of the Health Information Privacy Code is available for further information if desired.

I consent to Kensington Hospital obtaining my (or my child's) medical records and investigation results (eg lab tests, radiology), and to collect and store health information for the purpose of assisting in my (or my child's) care and treatment, and in administering and monitoring this care. Kensington Hospital may share any information that is directly related to my healthcare with third parties, such as health insurers, medical specialists, and ACC.

If you have not received a pre-operative phone call 24 hours prior to your admission date, please contact Kensington Hospital at your earliest convenience.

Sign here Date

Please print name

The above details have been completed by: patient guardian relative other (specify)

JOPI713J



Please complete and return seven days prior to admission to:
 PO Box 8122, Kensington, Whangarei 0145

Personal Details

Surname First name(s)
 Preferred Name Male Female Ethnicity
 Date of birth Age Are you a NZ resident? YES NO
 Physical Address Postcode
 Postal Address Postcode
 Phone Number Home Business Mobile
 Email Address Your family Doctor

Allergies/Medical Alert

Do you have allergies to medications, tablets, plasters, food, LATEX or any other substance? YES NO
 If "YES" please list below.

Substance	Type of reaction	Substance	Type of reaction

Admission Details: (For office use only)

Special Instructions:

Date of Operation Time : Number of Nights
 NHI Number Surgeon Anaesthetist
 Proposed surgery
 LA/GA/SEDATION Day Case YES / NO IPS Bed Required YES / NO

Health Questionnaire

Please complete the following questions. They help provide our staff with necessary information to assess your health and plan your care. This information will remain confidential and form part of your medical records.

Your weight kg

Your height metres

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? Please complete all questions either Yes or No

- | | | |
|--|--|--|
| <p>Yes No</p> <p><input type="radio"/> <input type="radio"/> High blood pressure</p> <p><input type="radio"/> <input type="radio"/> Heart attack</p> <p><input type="radio"/> <input type="radio"/> Heart murmurs</p> <p><input type="radio"/> <input type="radio"/> Artificial heart valve</p> <p><input type="radio"/> <input type="radio"/> Pacemaker</p> <p><input type="radio"/> <input type="radio"/> Chest pains</p> <p><input type="radio"/> <input type="radio"/> Coronary angioplasty / stents</p> <p><input type="radio"/> <input type="radio"/> Rheumatic fever</p> <p><input type="radio"/> <input type="radio"/> Stroke / TIA</p> <p><input type="radio"/> <input type="radio"/> Irregular Heart Rate/AF</p>
<p><input type="radio"/> <input type="radio"/> Asthma</p> <p><input type="radio"/> <input type="radio"/> Tuberculosis</p> <p><input type="radio"/> <input type="radio"/> Emphysema/Bronchitis</p> <p><input type="radio"/> <input type="radio"/> Persistent cough</p> <p><input type="radio"/> <input type="radio"/> Shortness of breath</p> <p><input type="radio"/> <input type="radio"/> Obstructive sleep apnoea</p> <p><input type="radio"/> <input type="radio"/> Do you have a CPAP Machine</p> <p><input type="radio"/> <input type="radio"/> Anaemia</p> <p><input type="radio"/> <input type="radio"/> Bleeding disorder</p> <p><input type="radio"/> <input type="radio"/> Blood clots</p> <p><input type="radio"/> <input type="radio"/> Blood transfusion</p> <p><input type="radio"/> <input type="radio"/> Hepatitis A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/></p> <p><input type="radio"/> <input type="radio"/> HIV/AIDS</p> <p><input type="radio"/> <input type="radio"/> Kidney/Renal disease</p>
<p><input type="radio"/> <input type="radio"/> Diabetes T1 <input type="checkbox"/> T2 <input type="checkbox"/></p> <p>If you have diabetes, are you...</p> <p>Yes No</p> <p><input type="radio"/> <input type="radio"/> ...taking insulin?</p> <p><input type="radio"/> <input type="radio"/> ...taking tablets?</p> <p><input type="radio"/> <input type="radio"/> ...diet controlled?</p> | <p>Yes No</p> <p><input type="radio"/> <input type="radio"/> Disease of muscles or nerves</p> <p><input type="radio"/> <input type="radio"/> Malignant hyperthermia</p>
<p><input type="radio"/> <input type="radio"/> Epilepsy</p> <p><input type="radio"/> <input type="radio"/> Blackouts/fainting</p> <p><input type="radio"/> <input type="radio"/> Medicines for long term pain</p> <p><input type="radio"/> <input type="radio"/> Recreational drugs</p> <p><input type="radio"/> <input type="radio"/> Steroids</p> <p><input type="radio"/> <input type="radio"/> Joint implants</p> <p><input type="radio"/> <input type="radio"/> Arthritis</p> <p><input type="radio"/> <input type="radio"/> Contact lens</p> <p><input type="radio"/> <input type="radio"/> Hearing aid</p> <p><input type="radio"/> <input type="radio"/> Memory Problems eg. dementia</p>
<p><input type="radio"/> <input type="radio"/> Do you smoke?
If yes, how many daily?</p> <p><input type="radio"/> <input type="radio"/> Do you drink alcohol?
If yes, how much daily?</p>
<p><input type="radio"/> <input type="radio"/> Do you have any history of falls?
If yes, when was your last fall?
.....</p>
<p><input type="radio"/> <input type="radio"/> Do you have any special dietary requirements?</p>
<p><input type="radio"/> <input type="radio"/> Do you currently have any skin problems: rashes, ulcers, wounds, eczma or boils.</p> | <p>Yes No</p> <p><input type="radio"/> <input type="radio"/> Have you had an anaesthetic before?</p> <p><input type="radio"/> <input type="radio"/> General anaesthetic</p> <p><input type="radio"/> <input type="radio"/> Spinal/Epidural</p> <p><input type="radio"/> <input type="radio"/> Any problems during or after anaesthesia?</p> <p><input type="radio"/> <input type="radio"/> Do you have problems opening your mouth or with neck stiffness?</p> <p><input type="radio"/> <input type="radio"/> Do you have difficulty climbing one or two flights of stairs?</p> <p>Is activity restricted by:</p> <p><input type="radio"/> <input type="radio"/> Shortness of breath?</p> <p><input type="radio"/> <input type="radio"/> Chest pain?</p> <p><input type="radio"/> <input type="radio"/> Joint pain?</p> <p><input type="radio"/> <input type="radio"/> Muscle pain?</p> <p><input type="radio"/> <input type="radio"/> Does lying flat make you breathless?</p>
<p><input type="radio"/> <input type="radio"/> Do you have reflux/heartburn?</p> <p><input type="radio"/> <input type="radio"/> Are you or could you be pregnant?</p>
<p><input type="radio"/> <input type="radio"/> Dentures?</p> <p><input type="radio"/> <input type="radio"/> Have you been in a hospital either in NZ or overseas in the last 6 months?</p> <p>if YES:</p> <p>When</p> <p>Where</p> <p>How long</p> <p><input type="radio"/> <input type="radio"/> Have you ever had MRSA, VRE or ESBL infection?</p> <p><input type="radio"/> <input type="radio"/> Do you work in a healthcare facility?</p> |
|--|--|--|

If you have answered yes to any of the above, please explain (Details of surgery/hospital admissions overleaf):

.....

.....

.....

Do you suffer from any other conditions not already noted, that you think we should know about? Please state details of any disability, physical or emotional needs, cultural or spiritual needs. Please also include any dietary restrictions.

.....

.....

Do you require an interpreter?:

Please list all previous admissions to hospital / surgical procedures:

Reason for admission	Hospital	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	Dose	Frequency

Are you taking any anticoagulants or blood thinning medications? eg: Warfarin, Dabigatran, Clopidogrel, Xareito, Asprin etc.

Yes **No** **Type:**

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 IF YOU ARE STAYING OVERNIGHT.

Social Yes No

Do you use any mobility aids, ie. walking frame / wheelchair / hoist? TYPE:

Do you have any difficulties with any activities of daily living e.g. dressing/housework/showering? if yes, please give further details.

.....

.....

Do you currently receive any community services, ie. Homehelp?

If yes, please give further details.

.....

Do you have any dependants that need assistance?

If yes, please give further details.

.....

Do you live alone?
Who will care for you on discharge for the first 24 hours? (must be 16 years or over)

Name: Contact details:

Who will take you home on discharge?

Name: Contact details: