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 give permission to Kensington Hospital or any health professional involved in my care for this admission to Hospital, to access health information about me (or my child) that is relevant to my current treatment, which may be help by Southern Cross Hospitals, other health professionals or other health organisations.

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)

JOP1713J

Kensington HOSPITAL

12 Kensington Avenue, Whangarei 0112

"Enhancing Health through clinical excellence"

"Kia Rangatira ai nga Huarahi Hauora"

ADMISSION FORM

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***

Yes	No	
◯	◯	High blood pressure
◯	◯	Heart attack
◯	◯	Heart murmurs
◯	◯	Artificial heart valve
◯	◯	Pacemaker
◯	◯	Chest pains
◯	◯	Coronary angioplasty / stents
◯	◯	Rheumatic fever
◯	◯	Stroke / TIA
◯	◯	Irregular Heart Rate/AF
◯	◯	Asthma
◯	◯	Tuberculosis
◯	◯	Emphysema/Bronchitis
◯	◯	Persistent cough
◯	◯	Shortness of breath
◯	◯	Obstructive sleep apnoea
◯	◯	Do you have a CPAP Machine
◯	◯	Anaemia
◯	◯	Bleeding disorder
◯	◯	Blood clots
◯	◯	Blood transfusion
◯	◯	Hepatitis A☐ B☐ C☐
◯	◯	HIV/AIDS
◯	◯	Kidney/Renal disease
◯	◯	Diabetes T1☐ T2☐

If you have diabetes, are you...

Yes	No	
◯	◯	...taking insulin?
◯	◯	...taking tablets?
◯	◯	...diet controlled?

Yes	No	
◯	◯	Disease of muscles or nerves
◯	◯	Malignant hyperthermia
◯	◯	Epilepsy
◯	◯	Blackouts/fainting
◯	◯	Medicines for long term pain
◯	◯	Recreational drugs
◯	◯	Steriods
◯	◯	Joint implants
◯	◯	Arthritis
◯	◯	Contact lens
◯	◯	Hearing aid
◯	◯	Memory Problems eg. dementia
◯	◯	Do you suffer from anxiety?
◯	◯	Do you have a history of mental health illness? If yes, please explain
◯	◯	Do you smoke? If yes, how many daily? .....
◯	◯	Do you drink alcohol? If yes, how much daily? .....
◯	◯	Do you have any history of falls? If yes, when was your last fall?
◯	◯	Do you have any special dietary requirements?
◯	◯	Do you currently have any skin problems: rashes, ulcers, wounds, eczma or boils.
◯	◯	Has your doctor ordered any tests? If yes, what tests?

Yes	No	
◯	◯	Have you had an anaesthetic before?
◯	◯	General anaesthetic
◯	◯	Spinal/Epidural
◯	◯	Any problems during or after anaesthesia?
◯	◯	Do you have problems opening your mouth or with neck stiffness?
◯	◯	Do you have difficulty climbing one or two flights of stairs?

Is activity restricted by:

Yes	No	
◯	◯	Shortness of breath?
◯	◯	Chest pain?
◯	◯	Joint pain?
◯	◯	Muscle pain?
◯	◯	Does lying flat make you breathless?
◯	◯	Do you have reflux/heartburn?
◯	◯	Are you or could you be pregnant?
◯	◯	Dentures?
◯	◯	Have you been in a hospital either in NZ or overseas in the last 6 months?

if YES:

When .....

Where .....

How long .....

Yes	No	
◯	◯	Have you ever had MRSA, VRE or ESBL infection?
◯	◯	Do you work in a healthcare facility?
◯	◯	Have you been in a rest home or correctional facility in the last 6 months?

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: .....

Have you arranged someone to take you home on discharge? ◯ ◯

Name: ..... Contact details: .....

P.T.O