

A



**Patient to complete A, B & C and return to the hospital
PRIOR TO ADMISSION to confirm your booking**

Admissions, PO Box 31459, Lower Hutt
666 High Street, Lower Hutt 5040
Phone: 569-7555 • Fax: 567-0041

Surname Given Names Mr/Mrs/Ms/Miss/Master
Date of Birth Age Sex: M/F Ethnicity(optional)
Address Postcode
Telephone (H) (Bus) (Mobile)
Family Doctor NHI No (if known)

Emergency Contact Name Relationship
Address
Telephone (Day) (A/h)

Type of Accommodation: Single Room Double Room Short Stay Parent Rooming in

Special Dietary Requirements (please state)

Any other special needs – physical/cultural/spiritual/communication (please state)

Procedure:

Surgeon: **Admission Date:**

Have your hospital treatment costs been approved by:

ACC: YES / NO If so, ACC No:

Medical Insurance: Policy No: Approval No:

Name of Company:

Payment will be made by: (please tick) Credit Card Cheque Cash Eft Pos

All costs are an APPROXIMATION only

HOSPITAL ADMINISTRATION ONLY

Consent form checked Y N
Anaesthetist advised Y N
Hospital advised Y N
Hospital Notes/X-ray files available Y N/A

Admission Clerk Principal Nurse
(Signature) (Signature)

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B

It is important that you answer all questions as accurately as possible. All information is sought to minimise your risk and will be retained as part of your confidential clinical records.

• Do you suffer from, or have you ever suffered from, the following? (circle Y for yes, N for no)

- | | | | |
|---|-------|--------------------------------------|-------|
| Chest pains/tightness or Angina | Y / N | Shortness of breath | Y / N |
| Previous Rheumatic Fever | Y / N | Asthma | Y / N |
| Previous Heart Attack | Y / N | Emphysema or Bronchitis | Y / N |
| Palpitations | Y / N | Tuberculosis | Y / N |
| Heart Murmur | Y / N | Obstructive Sleep Apnoea | Y / N |
| High Blood Pressure | Y / N | Persistent Cough | Y / N |
| Artificial Heart Valve or Pacemaker | Y / N | Stroke or Seizures | Y / N |
| Hiatus Hernia/Heartburn/Indigestion | Y / N | Jaundice or Hepatitis | Y / N |
| Diabetes | Y / N | Please specify type (if known) | |
| Insulin <input type="checkbox"/> Oral Medication <input type="checkbox"/> | | Kidney Disease | Y / N |
| Diet Controlled <input type="checkbox"/> | | Thyroid Disease | Y / N |
| Rheumatoid Arthritis | Y / N | Previous DVT or Lung Embolus | Y / N |
| HIV/Aids | Y / N | Prostate Conditions | Y / N |

Your Weight:kg

Your Height:metres

Do you:

Smoke: Y / N How many?

Drink Alcohol: Y / N How much?

How often?

Are you at risk of exposure to Hepatitis: Y / N

• If you have answered yes to any of the above or have any other illness, please give further details below.

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• Please list previous hospital admission including year and hospital (if known).

Reason for admission	Date	Hospital
.....
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.....

• What medications (including herbal)/drugs are you taking?

Medication	Dose	Time Taken
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.....
.....
.....
.....

Patient ID



- **Do you have problems opening your mouth?** YES/NO
- **Have you been told of previous problems with your airway under anaesthesia?** YES/NO
- **Do you have any of the following:** (please tick those that apply)
 - dentures partial plate capped or loose teeth
- **What physical activity(ies) do you take part in on a regular basis?** (please tick those that apply)
 - walking gym work tennis golf others (list) _____
- **I can climb** **one** **two** **or more flights of stairs without getting short of breath.**
- **My activity is restricted by:** (please tick those that apply)
 - shortness of breath chest pain joint pain
- **Women only – Are you, or could you, be pregnant?** YES/NO

SUBSTANCE		TYPE OF REACTION	YES/NO
.....		
.....		
.....		
.....		

- **Are there any major illnesses, to your knowledge, within your blood relatives eg; diabetes, muscular dystrophy, malignant hyperthermia etc?** If so, please outline YES/NO

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- **Have you been in any other hospital/resthome in the last 6 months?** YES/NO
- **Have you ever previously cultured MRSA?** YES/NO
- **Have you or any of your family had problems with anaesthetic?** If so, please outline YES/NO

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- **Do you suffer from any other conditions, not covered elsewhere, that you feel we should know about?** If so, please outline YES/NO

.....

.....
- **Do you have any concerns or questions about your anaesthetic?** If so, please outline YES/NO

.....

.....

The details above have been completed by: [PLEASE SIGN BELOW]

patient guardian relative or other? (please tick)

Signed: **Date:**

To be completed upon admission

Has there been any change in your health since completing the questionnaire? YES/NO

Have you been well in the past month? If not, please outline changes or health problems.

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Patient ID

TO BE COMPLETED BY THE ADMITTING NURSE

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	WARD	THEATRE
1. Identification band correct.....	Y <input type="checkbox"/> <input type="checkbox"/> N	Y <input type="checkbox"/> <input type="checkbox"/> N
2. Do you understand the operation/procedure you are having?.....	Y <input type="checkbox"/> <input type="checkbox"/> N	Y <input type="checkbox"/> <input type="checkbox"/> N
3. CONSENT FORMS		
• Correct operation signed for	Y <input type="checkbox"/> <input type="checkbox"/> N	Y <input type="checkbox"/> <input type="checkbox"/> N
Signed by patient	Y <input type="checkbox"/> <input type="checkbox"/> N	Y <input type="checkbox"/> <input type="checkbox"/> N
Signed by surgeon.....	Y <input type="checkbox"/> <input type="checkbox"/> N	Y <input type="checkbox"/> <input type="checkbox"/> N
• Anaesthetist consent signed	Y <input type="checkbox"/> <input type="checkbox"/> N	Y <input type="checkbox"/> <input type="checkbox"/> N
• Blood/blood products consent signed	Y <input type="checkbox"/> <input type="checkbox"/> N	Y <input type="checkbox"/> <input type="checkbox"/> N
• Teaching and photographic images consent signed.....	Y <input type="checkbox"/> <input type="checkbox"/> N	Y <input type="checkbox"/> <input type="checkbox"/> N
• Health information consent signed	Y <input type="checkbox"/> <input type="checkbox"/> N	Y <input type="checkbox"/> <input type="checkbox"/> N
4. Correct site marked for surgery (by consultant).....	Y <input type="checkbox"/> <input type="checkbox"/> N	Y <input type="checkbox"/> <input type="checkbox"/> N
5. Allergies	Y <input type="checkbox"/> <input type="checkbox"/> N	Y <input type="checkbox"/> <input type="checkbox"/> N
6. Nil by mouth from.....hours	Y <input type="checkbox"/> <input type="checkbox"/> N	Y <input type="checkbox"/> <input type="checkbox"/> N
7. Artificial joints or heart valves.....	Y <input type="checkbox"/> <input type="checkbox"/> N	Y <input type="checkbox"/> <input type="checkbox"/> N
8. X-rays/notes/scans (if applicable)	Y <input type="checkbox"/> <input type="checkbox"/> N	Y <input type="checkbox"/> <input type="checkbox"/> N
9. Medical/pathology reports.....	Y <input type="checkbox"/> <input type="checkbox"/> N	Y <input type="checkbox"/> <input type="checkbox"/> N
10. Body parts/tissue returned (see informed consent form)	Y <input type="checkbox"/> <input type="checkbox"/> N	Y <input type="checkbox"/> <input type="checkbox"/> N
If yes, brochure given	Y <input type="checkbox"/> <input type="checkbox"/> N	Y <input type="checkbox"/> <input type="checkbox"/> N
11. Health Questionnaire Completed	Y <input type="checkbox"/> <input type="checkbox"/> N	Y <input type="checkbox"/> <input type="checkbox"/> N
12. Dentures or plates.....	Y <input type="checkbox"/> <input type="checkbox"/> N	Y <input type="checkbox"/> <input type="checkbox"/> N
13. Contact lenses.....	Y <input type="checkbox"/> <input type="checkbox"/> N	Y <input type="checkbox"/> <input type="checkbox"/> N
14. Jewellery (taped/removed)	Y <input type="checkbox"/> <input type="checkbox"/> N	Y <input type="checkbox"/> <input type="checkbox"/> N
15. Hearing loss (circle) L R Bilateral N/A		
Hearing aid with patient	Y <input type="checkbox"/> <input type="checkbox"/> N	Y <input type="checkbox"/> <input type="checkbox"/> N
16. Bladder emptied	Y <input type="checkbox"/> <input type="checkbox"/> N	Y <input type="checkbox"/> <input type="checkbox"/> N
17. Shave and skin preparation	Y <input type="checkbox"/> <input type="checkbox"/> N	Y <input type="checkbox"/> <input type="checkbox"/> N
18. Skin integrity intact.....	Y <input type="checkbox"/> <input type="checkbox"/> N	Y <input type="checkbox"/> <input type="checkbox"/> N
19. Pre-medication given (if applicable)	Y <input type="checkbox"/> <input type="checkbox"/> N	Y <input type="checkbox"/> <input type="checkbox"/> N
20. Bowel Prep	Y <input type="checkbox"/> <input type="checkbox"/> N	Y <input type="checkbox"/> <input type="checkbox"/> N
21. Pregnancy test (if applicable)	Y <input type="checkbox"/> <input type="checkbox"/> N	Y <input type="checkbox"/> <input type="checkbox"/> N
Result..... If positive, consultant advised.....	Y <input type="checkbox"/> <input type="checkbox"/> N	Y <input type="checkbox"/> <input type="checkbox"/> N
22. Other (annotate).....	Y <input type="checkbox"/> <input type="checkbox"/> N	Y <input type="checkbox"/> <input type="checkbox"/> N
Signature of Admitting Nurse	(Wd)	(Th).....
23. Will you be accompanied home?.....		Y <input type="checkbox"/> <input type="checkbox"/> N
24. Will you have someone at home with you in the immediate post-operative period?		Y <input type="checkbox"/> <input type="checkbox"/> N
25. Who will instill drops (Ophthalmology patients only)? Name		

Any alterations to be annotated in red pen and signed by patient

Signature of Patient Date.....

Signature of Admitting Nurses: Date.....

Patient ID