ST MARKS ROAD
SURGICAL CENTRE

Pre-Admission Forms

Please complete the forms in this booklet and return them to St Marks Road Surgical Centre as soon as possible.

Please ensure all sections of all three forms are completed so that we are able to meet your individual needs and deliver the best possible care to you.

You may return the completed forms to:
St Marks Road Surgical Centre, 3 St Marks Road, Remuera, Auckland 1050.
St Marks Road Surgical Centre, PO Box 109149, Newmarket, Auckland 1149.
Fax: (09) 523 5249

If faxing, please ensure that both sides of the double sided forms are faxed, and that you bring the original forms with you on the day of admission.

If you have any questions about the forms, please contact St Marks Road Surgical Centre on 09 523 5243, or your surgeon's rooms.

Privacy: Information and personal data gathered for the purpose of your visit to St Marks Road Surgical Centre is covered by the Health Information Privacy Code and the Privacy Act 1993. If you have any concerns regarding this, please contact the St Marks Road Surgical Centre Facility Manager on (09) 523 5243.

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Agreement to Treatment

Please complete this form and return it to St Marks Road Surgical Centre as soon as possible.

Family name: _____ First names: _____

Date of birth: _____ Surgeon: _____
Day Month Year

Proposed procedure/operation/treatment: (this section to be completed by surgeon)

_____

_____

_____

Operative side of body: Left ☐ Right ☐ Bilateral ☐ Not applicable ☐
(Please tick)

Proposed anaesthesia: GA ☐ LA ☐ Regional ☐ Sedation ☐
(Please tick)

Procedure date: _____ Procedure time: _____ am / pm
Day Month Year

Type of stay: Day stay ☐ Overnight stay ☐
(Please tick)

Surgeon's instructions for St Marks Road Surgical Centre:

_____

_____

_____

Procedural Consent

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

above performed on myself/my child/my relative _____
(Patient's name)

I have been able to discuss this with the surgeon named above.

I have had adequate opportunity to ask questions and have received all the information I want. I understand that I am able to ask for more information if I wish. 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 agree to anaesthesia / sedation as detailed overleaf.

I agree to the administration of blood / blood products as required.

I understand that should a member of the healthcare team be directly exposed to my blood or other bodily fluids, I agree to blood samples being taken and tested. These samples will be tested only to identify such transmissible diseases that are considered of significant risk e.g. Hepatitis and HIV. I understand that 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 for the medical team involved in my care during this admission to access health information that is relevant to my current treatment. I agree to procedural images as required.

Surgeon's signature: _____ Date: _____
Day Month Year

Patient's/Guardian's signature: _____ Date: _____
Day Month Year

Patient's name:

Anaesthetist name: _____

Proposed anaesthetic technique(s): (this section to be completed by anaesthetist)

_____

_____

_____

Anaesthetic technique(s): GA ☐ Sedation ☐ MAC ☐ LA ☐ Regional ☐ Spinal ☐ Epidural ☐
(Please tick)

Anaesthetist's instructions for St Marks Road Surgical Centre:

_____

_____

_____

_____

_____

_____

Anaesthetic Consent

You should leave this section blank until you have seen your anaesthetist – which may be on the day of surgery.

I, _____ agree to have the anaesthetic technique(s) described
(Patient's/Guardian's full name)

above performed on myself / my child / my relative _____
(Patient's name)

I understand that having an anaesthetic or sedation involves risks which are separate from, and are in addition to the risks of the operation/ surgical procedure that I am to undergo.

I have been able to discuss this with the anaesthetist named above.

I have had adequate opportunity to ask questions and have received all the information I want. I understand that I am able to ask for more information if I wish. I confirm that I have received a satisfactory explanation of the reasons for, risks and likely outcomes of the particular anaesthetic / sedative technique(s) detailed.

I agree to have this anaesthetic, and to any other measures that may be found to be necessary during the course of the procedure.

I acknowledge that the anaesthetic or sedation has residual or "hangover" effects that may impair my judgement and performance, and that this will be prolonged if I take alcohol, sedatives or recreational drugs. I understand that because of this I should not drive a motor vehicle, operate potentially dangerous machinery or appliances, drink alcohol, or make important decisions for 24 hours after the anaesthetic or sedation, and that I may need to limit my activities for a longer period of time if advised to do so.

I understand that if I am going home on the same day as my operation / surgical procedure, I should be accompanied on the journey by a responsible person, and should have a responsible person stay with me in the same house that night.

I give permission for the medical team involved in my care during this admission to access health information that is relevant to my current treatment.

Anaesthetist's signature: _____ Date: _____
Day Month Year

Patient's/Guardian's signature: _____ Date: _____
Day Month Year

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Patient Admission Form

Please complete this form and return it to St Marks Road Surgical Centre as soon as possible.

Personal & Administration Details:

Family name: _____ ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Mstr ☐ Dr

First names: _____ Preferred name: _____

Date of birth: _____ Gender: ☐ Male ☐ Female NHI: _____

Day Month Year

Residential address: _____

Postal address: (If different) _____

Email address: _____ NZ Resident: ☐ Yes ☐ No

Telephone: (Home) _____ (Work) _____ (Mobile) _____

General practitioner: _____ Telephone: _____

Next of Kin/Contact Person:

Name: _____ Relationship to patient: _____

Residential address: _____

Telephone: (Home) _____ (Work) _____ (Mobile) _____

Payment Details: How will your procedure be paid for? Tick and complete as many options as applies.

☐ Health Insurance Please note – some personal expenses such as telephone calls may not be covered by your insurance company.

Name of insurer: _____ Policy No: _____

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

☐ Contract/ACC Please note – personal expenses such as telephone calls are excluded. A deposit may be required on admission if your costs are only partially funded.

☐ Paid personally If you paying for the procedure yourself, please note that in some instances a deposit or full payment will be required before admission. Please contact us or your surgeon to find out if this applies to you.

Settlement & Credit Card Authorisation:

I will pay my account by: ☐ Cheque ☐ Cash ☐ Credit Card ☐ Eftpos ☐ Internet banking

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

BNZ Newmarket 02 0192 0088501 00
Surname and initials required in reference section.

Card type: Mastercard Visa Please note – we do not accept American Express.

Credit card number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Expiry date: _____

Month Year

Name on card: _____ Signature: _____

I understand that signing this Credit Card Authority authorises St Marks Road Surgical Centre to debit my credit card with all amounts due and owing to St Marks Road Surgical Centre in relation to my admission and treatment on date: _____

Day Month Year

Agreement:

I agree to settle my hospital account in full at the time of my discharge when personally paying my account. I understand that I am responsible for any outstanding balance if my procedure is not fully covered by insurance or ACC. I accept that, in the event my hospital account is not met, St Marks Road Surgical Centre reserves the right to add all costs of collection to this account. I give permission to St Marks Road Surgical Centre to obtain from the relevant funder any information relating to the approval/claim for this admission, and I authorise that person or organisation to disclose such information to St Marks Road Surgical Centre. I understand that the admitting Surgeon, Anaesthetist and other doctors or health professionals using St Marks Road Surgical Centre are independent and not employees of St Marks Road Surgical Centre, with respect to my treatment, care and account payment. I accept this agreement is covered by New Zealand law.

Signature: _____ Date: _____

Day Month Year

Printed name: _____

Date of procedure _____

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Anaesthesia Assessment Health Questionnaire

Please complete this form and return it to St Marks Road Surgical Centre as soon as possible.

Family name: _____ First names: _____

Date of birth: _____ Phone number: _____
Day Month Year

Do you suffer from, or have you ever suffered from, the following: (Please tick)

Chest pains / tightness or angina	☐ Yes	☐ No	Shortness of breath	☐ Yes	☐ No
Heart attack / heart failure	☐ Yes	☐ No	Asthma or wheeziness	☐ Yes	☐ No
Palpitations	☐ Yes	☐ No	Emphysema or bronchitis	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No	Obstructive sleep apnoea	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No	Persistent cough	☐ Yes	☐ No
Artificial heart valve or pacemaker	☐ Yes	☐ No	Kidney disease	☐ Yes	☐ No
Rheumatic fever	☐ Yes	☐ No	Thyroid disease	☐ Yes	☐ No
Heart murmur	☐ Yes	☐ No	HIV / AIDS / risk of exposure to HIV	☐ Yes	☐ No
Stroke / TIA	☐ Yes	☐ No	Hepatitis B or C / jaundice	☐ Yes	☐ No
Epilepsy / seizures / blackouts	☐ Yes	☐ No	Are you a hepatitis carrier	☐ Yes	☐ No
Blood clots in legs or lungs	☐ Yes	☐ No	MRSA / MSO	☐ Yes	☐ No
Bleeding or clotting disorder	☐ Yes	☐ No	Hospital admission within the last 6 mths	☐ Yes	☐ No
Hiatus hernia / heartburn / indigestion	☐ Yes	☐ No	Recent exposure to infectious diseases	☐ Yes	☐ No
Diabetes – oral medication	☐ Yes	☐ No	Substance dependency (e.g. drugs, alcohol)	☐ Yes	☐ No
Diabetes – insulin dependent	☐ Yes	☐ No			

Do you: (Please tick)

Wear dentures/have capped or crowned teeth?	☐ Yes	☐ No	Smoke?	☐ Yes	☐ No
Have problems opening your mouth?	☐ Yes	☐ No	If "Yes", how many per day?	_____	
Wear contact lenses/glasses/hearing aid?	☐ Yes	☐ No	Drink alcohol?	☐ Yes	☐ No
Have any joint implants/prostheses/piercings?	☐ Yes	☐ No	If "Yes", how much?	_____	
Believe you may be pregnant?	☐ Yes	☐ No	Use recreational drugs?	☐ Yes	☐ No
Suffer from motion sickness?	☐ Yes	☐ No	If "Yes", please specify?	_____	

If you answered "Yes" to any of the above, please give further details below:

_____

_____

_____

Please list all current medications, drugs, tablets, inhalers, injections, herbal remedies, and supplements:

Medication / drug / remedy etc Dose Frequency

_____

_____

_____

_____

_____

Are you allergic to any medications, drugs, plasters, food, latex, or any other substance? ☐ Yes ☐ No

Substance Nature of reaction

_____

_____

_____

Please list previous surgery, including year and hospital if known:

Surgery	Year	Hospital

Have you or any of your family ever had a problem with an anaesthetic? ☐ Yes ☐ No

If "Yes", please give details below

What physical activity do you take part in on a regular basis? (Please tick)

Walking ☐ Gym work ☐ Tennis ☐ Golf ☐ Other: _____

How many flights of stairs can you climb without getting short of breath? (Please tick)

One flight ☐ Two flights ☐ Three flights or more ☐

My activity is limited by: (Please tick)

Chest pain ☐ Joint pain ☐ Shortness of breath ☐ Other: _____

Your weight: _____kg Your height: _____cm BMI: _____ (we will complete)

Are there any major illnesses, to your knowledge, among your blood relatives? ☐ Yes ☐ No

(e.g. diabetes, muscular dystrophy, malignant hyperthermia) If "Yes", please give details below

Do you suffer from any condition not listed elsewhere that you feel we should know about? ☐ Yes ☐ No

If "Yes", please give details below

Do you have any concerns or particular questions about your anaesthetic? ☐ Yes ☐ No

If "Yes", please give details below

Are there any additional matters that you wish to discuss before your surgery with: (Please tick)

Surgeon ☐ Anaesthetist ☐ Nurse ☐ Administration ☐

Do you have any special needs? (Please tick) If "Yes", please give details below

Disability	☐ Yes	☐ No	_____
Physical support or aids	☐ Yes	☐ No	_____
Religious, spiritual or cultural needs	☐ Yes	☐ No	_____
Dietary requirements	☐ Yes	☐ No	_____

If your surgery requires the removal of body parts, would you like them returned? ☐ Yes ☐ No

I give permission for my/my child's medical records and investigation results to be accessed for the purposes of assisting in my treatment ☐ Yes ☐ No

This form has been completed by: Patient ☐ Guardian ☐ Parent ☐ Other: _____

(Please tick)

Signature: _____ Date: _____

Day Month Year

Printed name: _____

Please bring all your medications with you to hospital.