Next of Kin / Contacts

1) Contact Person Relationship

Address

Phone Number Home Business Mobile

2) Contact Person Relationship

Address

Phone Number Home Business Mobile

Payment Details

Have your hospital costs been approved by:

Medical Insurance: Name of Company

Self

ACC ACC Claim No. App No.

ACC Injury Date. OP Code.

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 safe and will only be accessed by authorised personnel. You as a patient, have the right to access to your notes for as long as Northland Orthopaedic Clinic stores them.

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

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

I consent to Northland Orthopaedic Clinic obtaining my (or my child's) medical records and investigation results (e.g. Lab tests, radiology), 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.

Northland Orthopaedic Clinic may share any information that is directly related to my healthcare with third parties, such as health insurers, medical specialists and ACC.

You will be contacted pre-operatively to discuss your procedure, if you are unreachable do you give consent for a message to be left? YES ◯ NO ◯

If you have not received a pre-operative phone call 24 hours prior to your admission, please contact Northland Othopaedics on 437 9026.

Sign here Date

Please print name

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

Reviewed By:

Date:

Comments:

Northland Orthopaedic Clinic

Admission Form

Please complete and return to the clinic seven days prior to surgery.
Northland Orthopaedics Centre/Clinic
15 Kensington Avenue, Whangarei 0112
Phone 437 9026 - Fax 437 9033

Personal Details

Surname First name(s)

Preferred Name Male Female

Date of birth Age Ethnicity

Address Postcode

Postal Address Are you a NZ resident? YES ◯ NO ◯

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

NHI Number Surgeon Anaesthetist

Proposed surgery

LA/GA/SEDATION

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** _____

Have you ever had any previous operations? ◯YES ◯NO

Please detail .....

.....

Have you or any of your family been told of any difficulties during your anaesthetic? ◯YES ◯NO

If yes please detail .....

Have you ever suffered from post operative nausea / vomiting or motion sickness? ◯YES ◯NO

Do you suffer from, or have you ever suffered from any of the following?	**YES**	**NO**	**COMMENTS**
Heart disease, e.g. chest pain, rheumatic fever, heart attack, angina	◯	◯	.....
Heart murmur, palpitations	◯	◯	.....
Cardiac surgery ie. stents, Internal defibrillator, pacemaker, heart valves	◯	◯	.....
High blood pressure	◯	◯	.....
Lung disease e.g. Asthma, breathing troubles, TB	◯	◯	.....
Obstructive sleep apnoea	◯	◯	.....
Hiatus hernia, Indigestion	◯	◯	.....

Do any of the above restrict your activity?	**YES**	**NO**	**COMMENTS**
Liver disease e.g. jaundice, hepatitis B	◯	◯	.....
Kidney disease	◯	◯	.....
Abnormal bruising or bleeding	◯	◯	.....
Anaemia and other blood disorders	◯	◯	.....
Blood clots (legs or lungs)	◯	◯	.....
Diabetes	◯	◯	TYPE:.....
Epileptic fits	◯	◯	.....
Migraines or severe headaches	◯	◯	.....
Substance dependency e.g. morphine	◯	◯	.....
HIV or Hepatitis C	◯	◯	.....
Stroke, CVA, TIA, (Transient Ischaemic Attack)	◯	◯	.....
Dementia	◯	◯	.....
Mental illness requiring treatment	◯	◯	.....
Do you have problems with your neck or opening your mouth?	◯	◯	.....
Spinal problems (e.g. surgery)	◯	◯	.....

General Questions

	YES	**NO**	**COMMENTS**
Do you smoke? If yes, how many per day?	◯	◯	.....
Do you drink alcohol every day? If yes how much per day?	◯	◯	.....
Have you had MRSA/ESBL/ VRE/ a hospital borne infection?	◯	◯	.....
Have you been a patient/employee in a hospital in the last 6 months?	◯	◯	.....
Do you have any special dietary requirements?	◯	◯	.....
Do you suffer from any other condition, not covered elsewhere that you feel we should know about?	◯	◯	.....
Women only. Could you be pregnant?	◯	◯	.....

Patient Medications

Do you regularly take any pills, potions, medicines or drugs (including homeopathic and natural remedies)? Please list below all medications you are taking or detail on a separate sheet. Please discuss with your surgeon which medications you will need to take or withhold on the day of surgery (e.g. Warfarin, diabetic medications etc.) If you are staying in overnight, could you please attach a list of your current medicines from your pharmacy/GP and bring your medicines in with you. ◯YES ◯NO

Medication	**Dose**	**Times Taken**	**Medication**	**Dose**	**Times Taken**
.....	.....	.....	.....	.....	.....
.....	.....	.....	.....	.....	.....
.....	.....	.....	.....	.....	.....
.....	.....	.....	.....	.....	.....

Name of your usual Pharmacy..... Phone Number.....

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

◯YES ◯NO TYPE:.....

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 dependents 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:.....
Special requirements (e.g. visual or hearing difficulties, cultural needs) If so, please outline.	◯	◯	.....
Religious considerations If so, please outline.	◯	◯	.....
Do you require an interpreter? If yes, what language? .	◯	◯	.....