Admission Form

RODNEY SURGICAL
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Please complete and return this form to Rodney Surgical Centre, PO Box 317, Warkworth at least one week prior to your admission.
You will be contacted on the day before your surgery and advised of your admission and fasting times.

Personal Information

Surname First Name(s)

Mr/Mrs/Ms/Miss/Master

Preferred Name Date of Birth Age M F

Home Address

Postal Address

E-mail

Telephone Home Business Mobile

Occupation Ethnicity (optional)

Emergency Contact Name Relationship Telephone

Family Doctor Telephone

Payment Details

How will your procedure be paid for? *Tick and complete any sections required*

☐ **Health Insurance**

Name of Insurer Membership Number

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

☐ **ACC** (Personal expenses such as telephone calls are excluded) Approval Number

☐ **Paid Personally** ☐ **Other** (please define)

Agreement

- I understand that any costs given to me before surgery are **estimates** only and that I am responsible for any outstanding balance if my procedure is not fully covered by insurance, ACC or another contract. I accept that in the event that my hospital account is not paid, Rodney Surgical Centre reserves the right to add all costs of collection to this account.
- I understand that the surgeon, anaesthetist and any other doctor or health professional using Rodney Surgical Centre's facilities for operations, consultations or otherwise in relation to my care and treatment, and in relation to my account payment, are independent contractors and are not employees, agents or members of Rodney Surgical Centre. Accordingly, I accept that Rodney Surgical Centre is not liable for their actions or omissions.
- I understand that from time to time, other clinical personnel may be required to be in the theatre during my procedure.
- I give permission to Rodney Surgical Centre to collect and store information and clinical photos about me and my treatment with the understanding that any information will only be used for its intended purposes; that it will be kept securely in my medical file and/or computer system; shared only with health professionals involved in my care; government bodies will only be provided with information to which they are legally entitled. I have the right to check the accuracy of any information and to request corrections if necessary.

Patient/Guardian Signature: **Date:**

If not patient, state relationship:

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Patient Label

Health questionnaire

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. We are happy to help you complete this form if you so require.

Please list previous hospital admissions including date and hospital (if known).

Reason for admission	*Date*	*Hospital*

Have you ever had or do you currently have any of the following? *(Please tick* Yes *or* No *and* ***circle a word*** *where appropriate.)*

Diabetes: diet controlled/medication	Yes	☐	No	☐
Diabetes: requiring insulin	Yes	☐	No	☐
High blood pressure/ palpitations	Yes	☐	No	☐
Angina/heart attack/heart failure/chest pain	Yes	☐	No	☐
Stroke/TIA	Yes	☐	No	☐
Epilepsy/severe headaches	Yes	☐	No	☐
Blackouts/fainting	Yes	☐	No	☐
Asthma/wheeziness	Yes	☐	No	☐
Emphysema/bronchitis/croup	Yes	☐	No	☐
Persistent cough	Yes	☐	No	☐
Obstructive sleep apnoea	Yes	☐	No	☐
Rheumatic fever/heart murmur	Yes	☐	No	☐
Tuberculosis	Yes	☐	No	☐
Heart burn/acid reflux/hiatus hernia	Yes	☐	No	☐
Indigestion/stomach or peptic ulcer	Yes	☐	No	☐
Blood clots in legs/ lung	Yes	☐	No	☐
Bleeding problems/anaemia/bruising	Yes	☐	No	☐
Family history of bleeding problems	Yes	☐	No	☐
Glaucoma	Yes	☐	No	☐
Arthritis	Yes	☐	No	☐

If yes, which joints? ______

Thyroid disease	Yes	☐	No	☐
Kidney disease	Yes	☐	No	☐
Hepatitis A/B/C	Yes	☐	No	☐
Are you a hepatitis carrier	Yes	☐	No	☐
HIV/AIDS/risk of exposure to HIV	Yes	☐	No	☐
MRSA	Yes	☐	No	☐
Have you had a "head cold", throat/chest infection or bronchitis in the past 4 weeks?	Yes	☐	No	☐
Boils, skin or other infections/septicaemia?	Yes	☐	No	☐
If yes, please specify.				
Substance dependency/high use	Yes	☐	No	☐
Do you smoke/used to smoke?	Yes	☐	No	☐
If yes, how many per day?				
Do you drink alcohol daily?	Yes	☐	No	☐
If yes, how much?				

Do you have any of the following: (please circle)
dentures/partial plate/ capped/ loose teeth/contact lenses/ glasses/hearing aid/joint implants/pacemaker/heart valve/ other prosthetics/ implants/piercings

Do you believe you are pregnant?	Yes	☐	No	☐
If yes, how many months?				

Any other diseases or conditions? *If yes, please specify.*

______
______
______
______

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Allergies

Allergies: please list any reaction/allergy you have had, e.g. to medications, tablets, plasters, food, latex/rubber or other substances.

What medications (including herbal or contraceptive) are you (the patient) taking?

Medication	*Dose*	*Frequency*

Do you suffer from motion sickness? *Mild/moderate/severe* Yes No

Do you have difficulty climbing more than one flight stairs? *If yes, what restricts this activity?* Yes No

Have you had an anaesthetic before? Yes No

Have you or a family member had any problems with an anaesthetic before? *If yes, please outline.* Yes No

Do you have problems opening your mouth or have you had previous jaw problems? Yes No

Have you been told of previous problems with your airway under anaesthesia? Yes No

Do you have any concerns or questions about your anaesthetic? *If so, please outline.* Yes No

IN PREPARATION FOR ADMISSION - *add detail where necessary* Your weight Your height

Do you wish to retain body parts/metalware? Yes No
(A fee will apply for return of metalware)

Do you have a disability? Yes No

Physical support or aids? Yes No

Religious or spiritual needs? Yes No

Cultural or family/whanau needs? Yes No

Dietary requirements Yes No

Do you require RSC to organise someone to stay with you overnight (fee applies) Yes No Interpreter required Yes No

The details above have been completed by: (Please tick and sign below)

Patient Guardian Relative Other (please specify)

If there are any changes to the above information before my admission, I will notify Rodney Surgical Centre immediately.

Signed: Date:

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Informed consent/Request for treatment (to be completed with Surgeon)

Date of procedure ____________ Time of appointment ____________

Patient/Guardian

I ____________ agree that I have received a reasonable explanation of intent, risks, alternative treatment options, likely outcome and associated costs of the following operation/treatment:

to be carried out on myself/relative ____________ **by Dr/Mr** ____________
(Please circle one) (Name of patient if patient not signing)

Specific risks are: ____________

In the event of a hospital staff member being accidentally contaminated by my blood or body fluids, I consent to a sample of my blood being taken for Hepatitis B and H.I.V. (Aids) screening. I shall be informed of the results and counselled in their significance.

I have had explained and understood the risks and benefits of the use of blood and blood products and have had the opportunity to discuss their use. I AGREE to receiving these products if required.

Patient/Guardian signature: ____________ If not patient, state relationship: ____________

Surgeon's signature: ____________ **Date:** ____________

Anaesthetic Assessment and Consent (to be completed with Anaesthetist)

ASA - I, II, III, IV PONV Yes ☐ No ☐ GI reflux Yes ☐ No ☐

Previous anaesthesia ____________

Family history of GA problems ____________

Past medical history ____________

Airway ____________

CVS ____________

RS ____________

Dentition ____________

Lab results ____________

Summary of general status ____________

I understand that I require an anaesthetic for the above procedure. I understand that having an anaesthetic involves risks, and are in addition to the risks of the operation and procedure that I am having. I have had the opportunity to ask questions and have received all the information I want regarding its nature and effects. I give my informed consent to receiving an anaesthetic. I acknowledge not to drive a motor vehicle following my anaesthetic. I understand that I may receive Section 29 medications about which I will receive information post-operatively.

Patient signature: ____________

Anaesthetist name: ____________ Anaesthetist signature: ____________

Date: ____________ Proposed anaesthetic: ☐ GA ☐ MAC/S ☐ MAC ☐ SEDATION

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