1. Agree to treatment

Franklin Hospital

IMPORTANT: *Please return this completed form to Franklin Hospital.*

THIS SECTION IS COMPLETED BY THE ADMITTING DOCTOR

Surname (family name): _____

First name (s): _____

Patient's date of birth: ____ / ____ / ____ (d / m / y) Diagnosis: _____

Procedure/operation/treatment description: _____

Operative side of body: Left / Right / Bilateral / Not applicable *(please circle)*

Sedation: Yes ☐ No ☐ Anaesthesia: Yes ☐ No ☐ Proposed anaesthesia: general / local / regional / spinal / epidural *(please circle)*

Admission details

Admission date: ____ / ____ / ____ (d / m / y) Admission time: _____ Procedure/Surgery date: ____ / ____ / ____ (d / m / y) *(If different to admission date)*

Day stay unit ☐ Day inpatient ☐ Overnight inpatient ☐ Anticipated length of stay _____ hours / days / nights

Admitting doctor's instructions: _____

Admitting doctor's name: _____ Surgeon / Physician / General Practitioner *(please circle)*

Admitting doctor's signature: _____ **Date:** ____ / ____ / ____ (d / m / y)

(Where applicable please attach evidence of enduring power of attorney)

THIS SECTION IS COMPLETED BY THE PATIENT/GUARDIAN/ENDURING POWER OF ATTORNEY

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

above performed on myself / my child _____ at Franklin Hospital.
(Please circle) *(Name of patient, if patient not signing form)*

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 have had an opportunity to ask questions and understand that I may seek more information at any time and participate in decision making about my treatment.

I have been provided with sufficient information by my doctor in relation to the administration of blood components / blood products if necessary.

I give consent to the administration of blood or blood products if necessary: Yes ☐ No ☐

I understand that should a member of the healthcare team be directly exposed to my blood or other body fluids, I agree to blood samples being taken and tested. These samples will be tested only to identify such transmissible diseases as are considered of significant risk (e.g. Hepatitis and HIV). I understand 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 to Franklin Hospital or any health professional (such as my medical specialist) involved in my care in relation to this admission to Hospital, to access health information about me that is relevant to my treatment (including pre-admission and after discharge), which may be held by Franklin Hospital, other health professionals or other health organisations.

Patient/Guardian signature: _____ **Date:** ____ / ____ / ____ (d / m / y)

If not patient, state relationship to patient: _____

(Where applicable please attach evidence of enduring power of attorney)

Please turn over

Franklin Hospital

Hospital Administration only
(Patient label)

ANAESTHESIA PLAN AND CONSENT

THIS SECTION IS COMPLETED BY THE ANAESTHETIST

Sedation: Yes ☐ No ☐ Anaesthesia: Yes ☐ No ☐ Proposed anaesthesia: general / local / regional / spinal / epidural
(please circle)

Other: _____

Risk discussion

Sore Throat ☐ Nausea/Vomiting ☐ Dental Damage ☐ Allergic Reaction ☐ Itch ☐ Blood Clots ☐
Block Failure ☐ Nerve Damage ☐ Headache ☐ Hypotension ☐ Rare Serious Events ☐ Pain ☐ Bleeding ☐
Other: _____

Pain Relief Plan

Oral ☐ Intravenous ☐ PCA ☐ Epidural ☐ Spinal ☐ Wound Catheter ☐ Other ☐
Discussion notes: _____

Anaesthetist Statement

I have discussed the proposed anaesthetic plan and possible alternatives with the:
Patient ☐ Parent/Guardian ☐ Spouse/Partner ☐ Next-of-kin ☐ EPOA ☐

Anaesthetist Signature: _____ **Date:** ____ (d) / ____ (m) / ____ (y)

Anaesthetist Name: _____

THIS SECTION IS COMPLETED BY THE PATIENT/GUARDIAN/ENDURING POWER OF ATTORNEY

I, _____ agree to anaesthesia/sedation being given to
(Patient's/Guardian's full name)

myself / my child _____
(Please circle) *(Name of patient, if patient not signing form)*

I confirm that I have received a satisfactory explanation of the reasons for, risks and likely outcomes of the anaesthesia and I have had the opportunity to ask questions and understand I may seek more information at any time.

I understand the proposed anaesthesia may change as deemed necessary by the Anaesthetist.

I acknowledge that I should not drive a motor vehicle, operate machinery or potentially dangerous appliances, or make important decisions for 24 hours after having had the anaesthesia.

Patient/Guardian signature: _____ **Date:** ____ (d) / ____ (m) / ____ (y)

If not patient, state relationship to patient: _____

(Where applicable please attach evidence of enduring power of attorney)

2. Patient admission form

Franklin Hospital

IMPORTANT: Please return this completed form to Franklin Hospital.

PERSONAL AND ADMINISTRATION DETAILS

Surname (family name): _____ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Mstr ☐ Dr ☐

First name (s): _____ **Preferred name:** _____

Date of birth: ____ (d) / ____ (m) / ____ (y) **Gender:** Male ☐ Female ☐ **NHI:** _____

Residential address: _____

Postal address: _____

Email address: _____

Telephone: (Home) _____ (Business) _____ (Mobile) _____

New Zealand resident: Yes ☐ No ☐

Ethnicity: European / Māori / Pacific Island / Asian / Middle Eastern / Latin American / African / Other _____
(Please circle one or more)

General Practitioner (Name): _____ **Telephone:** _____

Medical Centre: _____

NEXT OF KIN/CONTACT PERSON

Name: _____ **Relationship to patient:** _____

Address: _____

Telephone (Home) _____ (Business) _____ (Mobile) _____

PAYMENT DETAILS

How will your procedure be paid for? Tick and complete as many as applies:

☐ **Health insurance** (personal expenses such as telephone calls are excluded)

Name of Insurer: _____

Insurance Plan Name: _____ Membership No: _____

Have you obtained 'prior approval' for payment: Yes ☐ No ☐ Approval No: _____
(Provide your prior approval letter)

☐ **ACC** (personal expenses such as telephone calls are excluded) ☐ **DHB** (personal expenses such as telephone calls are excluded)

☐ **Paid personally** If you are paying for the procedure yourself, you may be asked to pay an estimated deposit 3-5 days before admission. The balance of your account must be settled on discharge.

I will pay my account by: EFTPOS ☐ Credit card ☐ Debit card ☐ Internet Banking ☐

For Internet Banking:

Payee: Franklin Private Hospital Limited **Bank a/c:** 12-3109-0123585-00

Particulars: Patient Name **Code:** Date of Surgery e.g. 12 Sep 2021 **Reference:** Invoice number

AGREEMENT

I agree to settle my hospital account in full at the time of my discharge when personally paying my account or where I do not have 'prior approval' from my insurer. I understand I am responsible for any outstanding balance if my procedure is not fully covered by insurance, ACC or other contract.

I give permission for Franklin Hospital to obtain any information relating to the approval/claim for this admission from the relevant funder(s), and I authorise that person or organisation to disclose such information to Franklin Hospital. I accept that, in the event my hospital account is not met, Franklin Hospital reserves the right to add all costs of collection to this account.

I give permission to Franklin Hospital or any health professional involved in my care for this admission to hospital, to access health information about me that is relevant to my current treatment, which may be held by Franklin Hospital, other health professionals or other health organisations. I understand that other clinical team members such as student nurses and qualified medical trainees may have supervised involvement with my care and that I have the right to decline their presence or contribution to my care delivery.

I understand the admitting Surgeon, Anaesthetist and other Doctors or health professionals using Franklin Hospital facilities are independent and not employees of Franklin Hospital, with respect to both my treatment, care and account payment. I accept that this agreement is covered by New Zealand law. The details above have been completed by:

Name: _____ **Date:** ____ (d) / ____ (m) / ____ (y)

Signature: _____ **If not patient, state relationship to patient:** _____

3. Patient health questionnaire

Franklin Hospital

IMPORTANT: Please return this completed form to Franklin Hospital.

The hospital needs to receive all three forms at least one week prior to your admission. You can hand deliver, scan and email, or post the forms. If you post the forms, please allow 1-2 extra weeks for delivery.

Please complete this questionnaire carefully as the information you supply helps us to provide you with the best and safest possible care during your stay at our hospital. The questionnaire has four sections:

A Your general health
B In preparation for your hospital admission
C In preparation for your procedure
D Your current medicines

Surname *(family name)* _____

First name *(s)* _____

Hospital Administration only
(Patient label)

Height _____ metres

Weight _____ kilograms

Surgeon _____

NHI *(if known)* _____

Occupation *(optional)* _____

All questions in this questionnaire are about the person being treated at the hospital (the patient). If you are filling this out for the patient, only provide information relating to the patient's health.

SECTION A: YOUR GENERAL HEALTH

A1. MEDICAL PROCEDURE HEALTH ALERTS

Do any of the following apply to you?

Q	Yes	No		*If* Yes
1	☐	☐	Difficulty climbing more than a flight of stairs	What restricts this activity?
2	☐	☐	Motion sickness	mild / moderate / severe *(circle one)*
3	☐	☐	Jaw problems (difficulty opening mouth)	Specify:
4	☐	☐	Problems with a previous anaesthetic	Specify:
5	☐	☐	Family history of problems with an anaesthetic	Specify:
6	☐	☐	Pacemaker or heart valve replacement	Specify:
7	☐	☐	Joint implants	Specify:
8	☐	☐	Other implants or prostheses	Specify:
9	☐	☐	Substance use or dependency	Specify:
10	☐	☐	Former smoker	When did you quit?
11	☐	☐	Currently on smoking cessation treatment	Specify:
12	☐	☐	Current smoker	How many per day?
13	☐	☐	Pregnant or possibly pregnant	Approximate due date:
14	☐	☐	Medic Alert bracelet or necklace wearer	Specify:

Franklin Hospital

Hospital Administration only
(Patient label)

SECTION A: YOUR GENERAL HEALTH *(continued)*

A2: YOUR MEDICAL CONDITIONS

Do you currently have, or have you previously had, any of the following conditions?
If **Yes**, please circle any applicable options and provide **comments** in the box below.

Q	Yes	No	
15	☐	☐	**Breathing conditions:** asthma | wheeziness | shortness of breath | bronchitis | croup | emphysema | COPD
16	☐	☐	**Sleeping conditions:** sleeplessness | severe snoring | obstructive sleep apnoea | CPAP used
17	☐	☐	**Heart conditions:** palpitations | irregular heart beat | heart murmur | angina | heart attack | chest pain congestive heart failure | rheumatic fever
18	☐	☐	**Stroke or Transient Ischaemic Attack (TIA)**
19	☐	☐	**High blood pressure or blood pressure controlled with medication**
20	☐	☐	**Blood clots**: deep vein thrombosis (DVT) | pulmonary em bolus (PE)
21	☐	☐	**Family history of blood clots**
22	☐	☐	**Blood or bleeding conditions:** anaemia | bruising
23	☐	☐	**Family history of blood or bleeding conditions**
24	☐	☐	**Stomach and digestive conditions:** indigestion | heartburn | acid reflux | hiatus hernia | peptic ulcer
25	☐	☐	**Bowel conditions:** irritable bowel syndrome | constipation | bowel disease
26	☐	☐	**Liver disease:** jaundice | hepatitis
27	☐	☐	**Kidney conditions**
28	☐	☐	**Diabetes:** requiring insulin | requiring tablets | diet controlled
29	☐	☐	**Thyroid conditions**
30	☐	☐	**Parkinson's disease**
31	☐	☐	**Epilepsy, seizures, blackouts or fainting**
32	☐	☐	**Migraines or severe headaches**
33	☐	☐	**Alzheimers or dementia**
34	☐	☐	**Mental function conditions:** head injury | concussion | confusion or disorientation
35	☐	☐	**Mental health conditions**
36	☐	☐	**Emotional conditions:** anxiety | phobia | post traumatic stress disorder (PTSD)
37	☐	☐	**Arthritis**
38	☐	☐	**Neck or back conditions**
39	☐	☐	**Gum or dental health conditions**
40	☐	☐	**Tuberculosis (TB)**
41	☐	☐	**HIV or AIDS**
42	☐	☐	**Infection or treatment for resistant organisms:** MRSA | ESBL | VRE | OTHER
43	☐	☐	**Cancer:** *If **Yes**, please specify and provide details of any recent treatment in the Comments box below*
44	☐	☐	**Other condition(s) not listed above:** *If **Yes**, please specify in the Comments box below*

RE QUESTION	YOUR COMMENT
19	*GP says my blood pressure is slightly high, but I am not taking any medicine.* *- - - Example - - -*

Need more space for your comments? Please continue on a separate sheet and attach it to this page.

Franklin Hospital

Surname *(family name)*

First name *(s)*

Hospital Administration only
(Patient label)

SECTION B: IN PREPARATION FOR YOUR HOSPITAL ADMISSION

B1. YOUR ALLERGIES, SENSITIVITIES, OR INTOLERANCES

Q	Yes	No	
45	☐	☐	Are you **allergic to latex?**
46	☐	☐	Do you have **any other allergies, sensitivities or intolerances?** *If **Yes**, please specify and describe the reaction using the box below*

	Item	Reaction
Skin related	Plasters - - - Example - - -	Rash - - - Example - - -
Medicine related		
Food related		
Other		

B2. YOUR NEEDS AND PREFERENCES

Please answer these questions to help us to tailor how we care for you.
*If you answer **Yes** to any of these questions, we may contact you to discuss your specific needs.*

Q	Yes	No	*If Yes*	
47	☐	☐	Do you have a **disability?**	*Specify*
48	☐	☐	Do you have **difficulty understanding English?**	*Your preferred language:*
49	☐	☐	Do you have any **religious or spiritual needs** you would like us to know about?	*Specify:*
50	☐	☐	Do you have any **cultural or family needs** you would like us to know about?	*Specify:*
51	☐	☐	Do you have any **other special needs** you would like us to know about?	*Specify:*
52	☐	☐	If your procedure requires the **removal of body parts**, would you like them returned to you if this is possible?	
53	☐	☐	Do you have any **dietary requirements?**	☐ vegetarian ☐ vegan ☐ diabetic ☐ gluten free ☐ halal ☐ dairy free ☐ other _____
54	☐	☐	Do you have any **specific food dislikes?** *For allergies or intolerances, refer to question **46***	Specify:

Franklin Hospital

Hospital Administration only
(Patient label)

SECTION C: IN PREPARATION FOR YOUR PROCEDURE

C1. MEDICAL PROCEDURE HISTORY

Q	Yes	No	
55	☐	☐	*Have you previously had any procedures/operations or other hospital admissions?* *- If **Yes**, please outline your previous admissions in the table below. If you need more space, please continue on a separate sheet and attach it to this page*

Procedure or event	Year	Hospital

C2. ANAESTHESIA CONSIDERATIONS

Q	Yes	No					
56	☐	☐	Have you had an **anaesthetic** before?	☐ *general*	☐ *spinal*	☐ *epidural*	☐ *unsure*
57	☐	☐	Do you have any of these **dental features?**	☐ *upper denture*	☐ *lower denture*	☐ *crown(s) / cap(s)*	
				☐ *partial plate*		☐ *loose or chipped teeth*	
58	☐	☐	Do you **drink alcohol?**	How much? _____			

C3. PERSONAL ITEMS

Do you use any of these personal items?

Q	Yes	No		*If **Yes**, use this space to provide details, if needed*
59	☐	☐	Mobility aids, such as a walking stick or cane	
60	☐	☐	Glasses or contact lenses	
61	☐	☐	Hearing aids	
62	☐	☐	Earrings or other piercing jewellery	

C4. BLOOD CLOT AND INFECTION CONSIDERATIONS

Q	Yes	No	
63	☐	☐	Have you recently been on a **long distance flight?**
64	☐	☐	In the past 3 days, have you had, or been in contact with anyone who has had, **vomiting or diarrhoea?**
65	☐	☐	In the past 7 days, have you experienced **flu-like symptoms**, or been in contact with anyone diagnosed with **influenza?**
66	☐	☐	In the past 4 weeks, have you had a **head cold, throat or chest infection, or bronchitis?**
67	☐	☐	In the past 12 months, have you travelled overseas, or been a patient or employee in a hospital or rest home in New Zealand or overseas? *If **Yes**, please specify* _____
68	☐	☐	Do you have any **boils, cuts, sores, scratches or other skin or urine infections?**

C5. OTHER CONCERNS

Q	Yes	No			
69	☐	☐	Is there anything we need to know that you prefer not to write on this questionnaire? If Yes, please discuss with your nurse or medical specialist when you arrive at the hospital		
70	☐	☐	Do you have anxieties, concerns, or questions you wish to discuss before your procedure? *If **Yes**, who would you like to speak with?*	☐ *your surgeon* ☐ *a nurse*	☐ *your anaesthetist* ☐ *one of our admin staff*

Franklin Hospital

Surname *(family name)* _____ **First name** *(s)* _____

Hospital Administration only
(Patient label)

SECTION D: YOUR CURRENT MEDICINES

For your safety, it is extremely important that your doctors and nurses know precisely which medicines you are currently using.

IMPORTANT INSTRUCTIONS

1. List below **all** medicines you currently use, and bring them with you to the hospital in their **original containers**
2. To ensure you are clear what to include, please use the **MEDICINE REMINDERS** table (right →)
3. If you have a medication card or printout from your GP or pharmacist, please bring it with you to the hospital, as well as completing the list below.

MEDICINE REMINDERS
Which of the examples below apply to you?

There are many **types** of medicine		Medicines come in many **forms**		Medicines are taken for many **common conditions**	
prescription medicines	*vitamins*	*tablets*	*patches*	*heart disease*	*infections*
herbal medicines	*supplements*	*capsules*	*suppositories*	*high blood pressure*	*diabetes*
natural medicines	*contraceptives*	*inhalers*	*creams*	*blood thinning*	*sleeplessness*
homeopathic remedies	*steroids*	*drops*	*injections*	*dietary deficiencies*	*epilepsy*
over-the-counter medicines		*syrups*	*other liquids*	*emotional conditions*	

D1. YOUR CURRENT MEDICINES

Patient to complete - list ALL medicines you currently use.

HOSPITAL USE ONLY

Name of medicine	**Strength**	**How much you use, and when**	**Reconciled:** Yes (**Y**) | No (**N**) | Not available (**NA**)				*Comment if No*	*ON ADMISSION: Date/time last taken*
			Medicine container	*Medication card*	*Patient or whānau/ family*	*Other (state) eg, 'phoned GP'*		
Paracetamol - - - Example - - -	*500mg*	*2 capsules every 6 hours*	–	–	–	–	–	–

FH0022 7/21

If required, please continue on the reverse

This is not a prescription or an instruction to administer medicines

Franklin Hospital

Hospital Administration only
(Patient label)

SECTION D: YOUR CURRENT MEDICINES *continued from reverse*

D1. YOUR CURRENT MEDICINES			HOSPITAL USE ONLY					
Patient to complete - list ALL medicines you currently use.			**Reconciled:** Yes (**Y**) | No (**N**) | Not available (**NA**)					
Name of medicine	**Strength**	**How much you use, and when**	*Medicine container*	*Medication card*	*Patient or whānau/ family*	*Other (state) eg, 'phoned GP'*	*Comment if No*	*ON ADMISSION: Date/time last taken*

This is not a prescription or an instruction to administer medicines