MercyAscot

CHECKLIST

Please ensure you have:

- ☐ Completed the Request & Consent for Treatment Form with surgeon
- ☐ Completed Patient Registration Form
- ☐ Completed Patient Health History Form
- ☐ Your prior approval letter from your health insurer on admission

Send all paperwork one week prior to admission.

- ☐ Mercy Hospital admissions to: PO Box 9911, Newmarket
- ☐ Ascot Hospital admissions to: Private Bag, Remuera

IMPORTANT

- ☐ Please bring all the medications you are presently taking to the hospital when you admit

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Patient Health History

Do you suffer from or have you ever had any of the following? Please answer all questions

15. High blood pressure? YES NO
If YES, is this being monitored/treated by your GP? YES NO

16. Heart problems (eg. heart attack, angina, irregular pulse, fluid on lungs, pacemaker, rheumatic fever palpatations, fainting, murmur, endocarditis)? YES NO
If YES, please list

17. Blood disorders (eg. anaemia, Von Willebrands disease)? YES NO
If YES, please explain:

18. Asthma? YES NO
If YES, have you recently been hospitalised? YES *Date:* NO

19. Lung problems (eg. recent bronchitis, emphysema, TB)? YES NO

20. Obstructive sleep apnoea (told you snore loudly then stop breathing)? YES NO
If YES, do you use a CPAP machine? YES *(please bring with you when admitted)* NO

21. A stroke (eg. CVA or TIA)? YES NO

22. Fits or seizures (eg. epilepsy)? YES NO
If YES, when was your last seizure?

23. Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ☐ Yellow Jaundice ☐ HIV ☐

24. Diabetes? YES NO
If YES, what treatment are you on? Diet ☐ Tablets ☐ Insulin ☐

25. Blood clots to the legs or lungs? YES NO

26. Rheumatoid arthritis? YES NO

27. Hiatus Hernia ☐ Heartburn ☐ Acid Reflux ☐

28. Are you, or could you , be pregnant? YES NO

29. Have you or a blood relative ever had any problems with any anaesthetic? YES NO
If YES, who and what happened?

30. Any other Medical Conditions (eg. Alzheimer's, psychiatric history)? YES NO
If YES, please specify

Discharge Planning

31. Do you live alone? YES NO
If YES, who is going to care for you on discharge?

32. Do you have caring responsibilities for others at home? YES NO
If YES, please specify

33. Have you had any falls recently? YES NO
If YES, please explain

34. Do you receive Home Health Services (eg. Meals on Wheels, District Nurse)? YES NO
If YES, please list

35. Has your surgeon arranged admission to a rehabilitation unit for you if required? YES NO

Please note: The hospital discharge time is 10.00am

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Patient Health History

This form is part of your health assessment prior to surgery. It is dealt with in strict confidence. Please answer all questions.

Name: Date:

Weight: kg Height: cm

1. Do you have any **allergies** or **sensitivities** to any medications, food, latex, sticking plasters or other ? **YES** ☐ **NO** ☐

Medication/Substance Name	Type of Reaction

2. Do you have any special dietary requirements? **YES** ☐ **NO** ☐

If YES, please specify

3. Do you smoke or have you ever smoked? **YES** ☐ **NO** ☐

If YES, how many a day, for how many years and how long ago?

4. Do you drink alcohol? **YES** ☐ **NO** ☐

If YES, how much and how often?

5. Do you take street drugs or narcotics other than those prescribed for you? **YES** ☐ **NO** ☐

6. Do you have any vision or hearing difficulties? **YES** ☐ **NO** ☐

If YES, please describe

7. Do you have any religious beliefs/practices or cultural needs we should be aware of? **YES** ☐ **NO** ☐

If YES, please describe

8. If you have a body part removed during surgery, do you want it returned to you? **YES** ☐ **NO** ☐

9. Do you have any skin problems (eg. ulcers, bruise easily, wounds or dressings)? **YES** ☐ **NO** ☐

If YES, please describe

10. Mobility *(If you are currently using walking aides, please bring these with you when you are admitted)*

Independent ☐ Using Equipment ☐ Requiring Assistance ☐ Completely Dependant ☐

Please specify

11. Have you had any previous operations or admissions to hospital? **YES** ☐ **NO** ☐

If YES, when, where and what for

Reason / Operation	Year	Hospital

12. Does anyone assist you with administration of your own medication? **YES** ☐ **NO** ☐

13. Is your medication packed in "compliance" (blister) packaging? **YES** ☐ **NO** ☐

14. Do you take any regular medications (including the contraceptive pill, inhalers, herbal remedies, pain medication, eye-drops, sprays or regular over-the-counter medications such as aspirin)? *LIST BELOW* **YES** ☐ **NO** ☐

Medication	Strength *(mg)*	Dose *(how much/how many)*	Frequency *(how often)*

Go to Question 15

Request & Consent for Treatment

SURGERY BEING PERFORMED AT: ☐ MERCY ☐ ASCOT

Patient Name: _____ Date of Birth: / /

Date of Admission: / / Time: _____

Referring Consultants: _____

ACC Contract ☐ ACC Non-Contract Surgeon Lead Provider ☐ Surgeon Contract, Non-Contract MercyAscot Lead Provider ☐

SPECIALIST TO COMPLETE

Diagnosis _____

Planned Procedure: _____

Proposed Date of Surgery: / / Operation Length: Length of Stay: _____

Body Side: Left ☐ Right ☐ Inpatient: ☐ Day Case: ☐

I have explained to _____ the benefits and risks of the above surgery treatment

(discussion)

Surgeon Name: Signature: Date: / /

PATIENT TO COMPLETE

I agree that I have received a reasonable explanation of intent, alternatives, risks and likely outcomes of the operation/treatment of _____ (procedure/description) to the _____ (left/right) side of my body. In the event that something unexpected is found during surgery, I authorise the surgeon to act in my best interests

I agree to the collection of personal health information from myself or my representative and authorise use of this information for purposes related to my health care.

In the event of a staff member receiving a 'needle stick injury' or other 'blood accident' from instrumentation used during my procedure, I consent to a blood sample being drawn from myself and tested for HIV the AIDS virus, Hepatitis B, Hepatitis C and any other blood test deemed necessary by my doctor. I understand I will be informed of such testing and the results if I request them.

(please circle one)

Patient/Guardian Signature: Date: / /

STAT MEDICATION ORDERS ON ADMISSION

Date	Drug	Dose	Route	Time	Authorised By	Given By	Time

Other preparations required (eg. TED's/SCD's), please specify: _____

Previous medical history: _____

INVESTIGATION REQUIRED (for the following, please tick either: A = Prior to Admission, B = On Admission, C = Not Required)

Electrolytes	A B C	Coag Screen	A B C	MSU	A B C	Ordered at Diagnostic Med Lab	☐
Routine Haematology	A B C	Group & Ab Screen	A B C	ECG	A B C	Ordered at Other Lab	☐
Urea & Creatinine	A B C	X match _____ units	A B C	X Rays	*(state)*		
	A B C		A B C				

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Patient Registration Form

Please Complete and return to MercyAscot prior to admission

Title (Please Circle) Mr Mrs Ms Miss Dr Other Gender: Male ☐ Female ☐

First Name(s): Date of Birth: / /

Family Name: Marital Status:

Country of Birth: NZ RESIDENT: Yes ☐ No ☐ NHI No.: ☐☐☐☐☐☐☐☐☐☐

Residential Address:

Postal Address *(if different from above)*:

Phone: Home ( ) Work ( ) Mobile ( )

Ethnic Group:

Interpreter services must be arranged through your surgeons room prior to admission.

Do you require an interpreter: Yes ☐ Language required: No ☐

If visiting from overseas: Address while staying in NZ

Phone ( )

Occupation:

Emergency Contact Person

Name:

Gender: Male ☐ Female ☐ Relationship to Patient

Residential Address:

Phone: Home ( ) Work ( ) Mobile ( )

Health Insurer

Name of Health Insurer: Policy Type:

Membership No.: Prior Approval No.:

Is your surgery covered by ACC Yes ☐ No ☐ ACC Approval granted:: Yes ☐ No ☐

ACC Claim No.: ACC Office: ACC Case Manager:

Family Doctor

Name:

Address: Phone: ( )

Surgeon / Specialist

Name: Date of Admission: Time of Admission:

Have you been a patient at Mercy or Ascot Hospitals before? Yes ☐ - Year: No ☐

Have you worked or been a patient in any Hospital within the last six months

Yes ☐ - Hospital Ward: City & Country No ☐

Do you have one of the following prescription cards? *(Please bring your card with you to Hospital to receive any subsidy you are entitled to)*

☐ High Use Health Card Expiry Date / ☐ Community Services Card Expiry Date /

☐ Prescription Subsidy Card Expiry Date / ☐ Other: Expiry Date: /

For urgent bookings please fax these forms
for ASCOT (09) 520-9508 for MERCY (09) 623-5702

otherwise post to: Ascot Hospital, Private Bag, Remuera or Mercy Hospital, P O Box 9911, Newmarket

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Patient Registration Form

Please Complete and return to MercyAscot prior to admission

Accommodation

(Please indicate room preference. Options only applicable to Mercy)

Mercy: ☐ Single Room with Ensuite ☐ Share Room ☐ Ward Room

- Room choice is not applicable to patients covered by ACC.
- We will make every effort to accommodate your room preference, but your choice may not be available or appropriate to your clinical needs.
- You will be charged the rate for the actual room allocated, regardless of your preference.

ACC Claims

Contract Claim:

If your medical procedure is an ACC Contract Claim, ACC will pay the hospital directly for all hospital and specialist's costs excluding personal expenses. Personal Expenses, such as toll or international calls, wine, beer and visitor meals are required to be paid on discharge.

Individual Claim:

If your medical procedure is an individual ACC Claim, a copy of the ACC Letter of Approval MUST be received by Customer Services prior to Admission. **ACC DOES NOT COVER FULL COSTS OF HOSPITALISATION**. A payment will be required on Admission for the estimated difference of cost.

Part ACC/Part Insurance:

Proof of prior approval is required on admission for the portion of your procedure that is covered by insurance. If you are not insured, you will be required to pay a portion of the estimated hospital costs on admission.

(For further details on ACC reimbursement practices please ask your ACC case manager)

Payment of Hospital Costs

For further information please refer to the Patient Information Booklet.

Payment will be made by ☐ credit card ☐ cheque ☐ cash ☐ EFTPOS ☐ other:

If you have no insurance, you will be required on admission, to pay a deposit equivalent to the estimated cost of the procedure.

We strongly recommend you contact Customer Services for an estimate of hospital costs prior to admission:

Mercy (09) 623 5700 **Ascot (09) 520 9575**

- I understand and give consent that relevant information may be supplied to an external credit reporting agency to obtain a credit report.
- I agree I am responsible and will pay for all costs incurred in connection with my treatment.
- I understand that MercyAscot may notify a credit reporting agency and/or instruct a debt collection agency should I default on any payment due by me to MercyAscot.
- I understand that any collection and/or legal costs incurred in recovering any debt will be charged to me.

Personal Property

- I understand and agree that MercyAscot is not and will not be responsible for loss of or damage to any personal property (including jewellery, dentures, watches, rings, glasses) which I may bring into the hospital

- I consent to MercyAscot sharing relevant information that is related to my healthcare and as required by third parties such as Health Insurers, Medical Specialists, ACC and for quality and audit purposes.
- To the best of my knowledge the information I have supplied to MercyAscot is correct.

Signature **Print name in full** **Date:** / /

Please complete Patient Health History overleaf