MANAAKI
BY MERCY

72 Newington Avenue, Maori Hill
Dunedin 9010
Phone (03) 467 6710
Fax (03) 467 6711
Email: manaaki@mercyhospital.org.nz

AFFIX PATIENT LABEL

OFFICE USE ONLY

PATIENT ADMISSION FORM

PLEASE COMPLETE AND RETURN TO MANAAKI A.S.A.P.

ADMISSION FORM

Please complete all areas (if not applicable, please indicate with N/A)

Date of Procedure:

Proposed Procedure:

Specialist name:

Personal Details

☐ Mr ☐ Mrs ☐ Miss ☐ Ms

☐ Other **Gender:** ☐ M ☐ F

Surname:

First Name(s):

Preferred Name:

Previous Surname: (if applicable)

Date of Birth:

DAY MONTH YEAR

Residential Address: (no P.O. Box please)

Post code

Postal Address: (if different to Residential)

Post code

Email:

Home Phone:

Cellphone:

Contact Person:

Relationship to patient: Phone:

You will need someone to pick you up soon after your procedure (and stay with you for 24 hours if you are having sedation/anaesthetic). If different from above, who will this be?

Name:

Phone:

General Practitioner: **GP Practice:**

General Practitioner's Address:

IMPORTANT: To ensure your surgery proceeds as planned, please complete this question that relates to possible contact with Multi Drug Resistant Organisms (bacteria that are very difficult to treat with antibiotics).

Have you been in a Hospital or Rest Home, either as a patient or a staff member, or travelled overseas in the last six months? **Yes** ☐ **No** ☐

If yes, please name the rest home:

Or hospital : Ward:

If staff, state position held:

What country/countries have you travelled to:

Language

Is English your first language? ☐ Yes ☐ No

Would you like us to arrange an interpreter? ☐ Yes ☐ No

(There is a cost involved.)

Will you use a family member as an interpreter? ☐ Yes ☐ No

Cultural /Spiritual/Religious Needs

If you have any specific needs, please state:

Which ethnic group do you belong to?
Mark the space or spaces that apply to you.

- ☐ New Zealand European
- ☐ Maori - Iwi
- ☐ Samoan
- ☐ Cook Island Maori
- ☐ Tongan
- ☐ Niuean
- ☐ Other European
- ☐ Chinese
- ☐ Indian
- ☐ Other (such as Dutch, Japanese, Tokelauan). Please state:
- ☐ Prefer not to state

Continued overleaf →

Issue Date: 01/02/17 DSAF v 1.1

HEALTH INFORMATION

Medical History

Have you ever had any of the following?

a. Heart conditions ☐ Yes ☐ No
b. High blood pressure ☐ Yes ☐ No
c. Artificial heart valve/pacemaker/defibrillator ☐ Yes ☐ No
d. Diabetes ☐ Yes ☐ No
e. Kidney disease ☐ Yes ☐ No
f. Respiratory/breathing conditions ☐ Yes ☐ No
g. Sleep apnoea* ☐ Yes ☐ No
h. Stroke or seizures* ☐ Yes ☐ No
i. Blood clots in the legs or lungs* ☐ Yes ☐ No
j. Bleeding or clotting disorder* ☐ Yes ☐ No
k. Previous cancer* ☐ Yes ☐ No
l. Varicose veins* ☐ Yes ☐ No
m. HIV/Hep B/Hep C ☐ Yes ☐ No
n. Do you wear a medic alert bracelet? ☐ Yes ☐ No
o. Any major illnesses among blood relatives? ☐ Yes ☐ No
p. Any other medical conditions? ☐ Yes ☐ No

If "Yes" to any of the above please explain:

Do you have any other condition that you think we should know about?

Your weight* kg Your height cm

Allergies

Do you have any allergies or sensitivities? (Medications, foods, latex, plaster or anything else?

☐ Yes ☐ No

If " Yes" , please list.

What do you react to?	Type of reaction (e.g. rash)

Dietary Requirements

If you have food allergies or dietary requirements, please state:

Medication

What medications are you taking? Include those prescribed by a Doctor and any purchased at a pharmacy, supermarket (e.g. Paracetamol) or health food shop (e.g. natural remedies). If you are unsure, please get a list from your GP or pharmacy to bring with you.

Name of Medication	Dose	How often

Are you taking any blood thinning medications e.g. Asprin, Warfarin, Pradaxa, Clopidogrel? ☐ Yes ☐ No

HEALTH INFORMATION

Surgical History

Please list previous surgery:

Surgery/Procedure	Hospital	Date

Anaesthetic History

Have you had any past problems or reactions to an anaesthetic? ☐ Yes ☐ No

Do you have problems with your jaw or opening your mouth? ☐ Yes ☐ No

If "Yes", please explain:

Clinical Tissue

If your procedure requires the removal of any body parts/ tissue, would you like them returned to you?

☐ Yes ☐ No

Women Only

Are you or could you be pregnant? * ☐ Yes ☐ No

Are you taking contraceptive Pill? * ☐ Yes ☐ No

Are you taking hormone replacement therapy (HRT)? * ☐ Yes ☐ No

Smoking/Alcohol

Do you smoke? * ☐ Yes ☐ No

If "Yes" how many per day?

Do you drink alcohol? ☐ Yes ☐ No

If "Yes" how much?

How often?

Activity/Mobility

Mobility *

Independent ☐

Completely dependant ☐

Require assistance ☐

Slips/trips/falls/faints last 12 months ☐

Do you have any of the following?

Visual impairment ☐ Yes ☐ No

Hearing impairment ☐ Yes ☐ No

Artificial joints/limbs ☐ Yes ☐ No

Walking aids ☐ Yes ☐ No

Dentures/Caps/Crowns ☐ Yes ☐ No

If "Yes", please provide details below:

*** Forms part of the VTE assessment**

Health Information and Privacy

It is our policy not to give your health information to anyone inquiring about you without your permission. Please name one person to whom we may give information while you are in hospital.

Any personal or health information collected from you or your health service providers is collected to ensure you receive the best care and treatment at Manaaki; for quality assurance activities and to fulfil legislative requirements. On discharge, your GP and other health agencies and insurers will be provided with information about your stay at Manaaki, in order for them to deliver appropriate services. Your rights provided for in the Health Information Privacy Code and the Privacy Act 1993 will be respected, included your right to access and, if necessary, request correction of any information we hold about you. If you have any concerns, please ask a staff member.

I certify that all particulars on this form are correct.

Signature: **Date:**

PAYMENT OF ACCOUNTS

Mercy Hospital reserves the right to charge interest at 2% per month on all unpaid balances owing after on month from date of invoice.

Payment Details

Account information can be found in the brochure in your admission pack.

How will your procedure be paid for?

☐ **Southern Cross**
(For Affiliated Provider Procedures membership number only required)
Membership No. _____ Approval No._____
Please attach or forward a copy of your approval prior to your admission

☐ **Other Insurance Company**
Company. _____ Approval No._____
Please attach or forward a copy of your approval prior to your admission

☐ **ACC** (Prescriptions will be charged to you)

☐ **Other** (e.g. District Health Board Contract)

☐ **Paying Personally**

☐ **On Behalf Of:** If a person other than patient paying account e.g. parent/guardian, then **please also complete "Person Responsible for Payment" section**

Person Responsible for Payment

Please complete this if someone other than the patient will be paying the account.

Name:

Contact No:

Address: (if differs to patient address)

Relationship to patient:

Agreement

- I understand and give consent that relevant financial information may be supplied to an external credit reporting agency to obtain a credit report.
- I understand that I am responsible for payment of all costs incurred in connection with the treatment.
- I understand that Mercy Hospital may notify a credit reporting agency and/or instruct a debt collection agency should I default on any payment due by me to Mercy Hospital.
- I understand that any collection and/or legal costs incurred in recovering debt will be charged to me.
- I give permission for Mercy Hospital to obtain any information relating to the approval/claim for this admission from the funder and I authorise disclosure of such information to and from that funder as necessary to settle any claims.

I have read and understood the Payment of Accounts information on this page and in the Manaaki by Mercy brochure

Person responsible for payment of account:

Signature **Date**

Checklist

Please ensure you have completed each of the following sections:

☐ Admission Information (page 1)
☐ Health Information (pages 2-3)
☐ Payment of Accounts (page 4)
☐ Obtained a printout from your GP of all medicines you are taking if required.

Please return this form completed at least one week prior to your procedure date.

How to return your form:
Drop if off in person
Post: Manaaki by Mercy
Private Bag 1919
Dunedin 9054

Fax: (03) 467 6711
Email: manaaki@mercyhospital.org.nz

If you need help filling out this form, please contact us on 03 467 6710

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