

PATIENT ADMISSION FORM

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

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:

Language

Is English your first language? Yes No
 Would you like us to arrange an interpreter?
 (There is a cost involved.) Yes No
 Will you use a family member as an interpreter? Yes No

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 procedure proceeds as planned, please complete this question.

Have you been in a Hospital or Rest Home, either as a patient or a staff member in the last six months?

Yes No
 If staff, what was your position?

If yes, please name Rest Home/Hospital:

Cultural /Spiritual/Religious Needs

If you have any specific needs, please state:

Which ethnic group do you belong to?

- | | |
|---|--|
| <input type="checkbox"/> New Zealand European | <input type="checkbox"/> Other European |
| <input type="checkbox"/> Maori - Iwi <input type="text"/> | <input type="checkbox"/> Chinese |
| <input type="checkbox"/> Samoan | <input type="checkbox"/> Indian |
| <input type="checkbox"/> Cook Island Maori | <input type="checkbox"/> Other (such as Dutch, Japanese, Tokelauan). Please state:
<input type="text"/> |
| <input type="checkbox"/> Tongan | <input type="checkbox"/> Prefer not to state |
| <input type="checkbox"/> Niuean | |

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

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:

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

PAYMENT OF ACCOUNTS

Mercy Hospital reserves the right to charge interest at 2% per month on all unpaid balances owing after one 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:	<input type="text"/>	Contact No:	<input type="text"/>
Address: (if differs to patient address)	<input type="text"/> <input type="text"/> <input type="text"/>	Relationship to patient:	<input type="text"/>

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:	<input type="text"/>	<input type="text"/>
	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 it off in person
Post: Manaaki by Mercy Fax: (03) 467 6711
Private Bag 1919 Email: manaaki@mercyhospital.org.nz
Dunedin 9054

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

