MERCY HOSPITAL
Exceptional care that makes a difference

72 Newington Avenue, Maori Hill, Dunedin 9010
Phone (03) 467 6601 , Fax (03) 464 0111
Email: bookings@mercyhospital.org.nz
www.mercyhospital.org.nz

AFFIX PATIENT LABEL

OFFICE USE ONLY

PLEASE COMPLETE AND RETURN TO MERCY HOSPITAL A.S.A.P.

ADMISSION FORM

ADMISSION INFORMATION

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

Date of surgery:

Surgeon:

Stay Over ☐ **Day Patient** ☐ **Outpatient** ☐

Proposed Procedure:

Personal Details

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

Sex: M ☐ F ☐ **Religion:**

Surname:

First names:

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)

Post code

Email:

Home phone:

Work phone:

Cell phone:

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
- ☐ Chinese
- ☐ Indian
- ☐ Other (such as Dutch, Japanese, Tokelauan). Please state:
- ☐ Prefer not to state

Next of kin:

Relationship to patient: Phone:

Contact person during hospital stay:(if different from above)

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 in the last six months?

Yes ☐ **No** ☐

If yes, please name the rest home:

Or hospital : Ward:

If staff, state position held:

Accommodation (If stay over)

4-bed ward ☐ Single ☐ **Additional charge applies, not covered by ACC or DHB.**

Does your child (a patient 12 years and under) require a parent guardian/caregiver to stay overnight?

Yes ☐ No ☐

Full name of parent/guardian staying over:

We will make every effort to accommodate your room preference, but your choice may not always be available.

Continued overleaf →

Issue Date: 01/08/18 AF v 12.1

PAYMENT OF ACCOUNTS

Please refer to our 'Account Information' brochure enclosed with your Admission Pack for additional information.

Payment of your account is due within 14 days of invoice date. Mercy Hospital reserves the right to charge interest at 2% per month (24% per annum) on all unpaid balances once one month has elapsed since the invoice date.

Payment Details (please tick as applies)

☐ **Southern Cross—Affiliated Provider procedure**
Membership No.

☐ **Southern Cross—Not an Affiliated Provider procedure**
Membership No.
Approval No.

☐ **Other Health Insurance**
Company
Approval No.

☐ **ACC**
Single room surcharges, telephone call costs and visitor meals will be charged to you.

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

☐ **Paying Personally**
Or if your costs are not fully covered by ACC or Health Insurance.
- ♦ We may ask you to pay a deposit prior to your admission.

☐ **On Behalf Of**
If a person other than the patient is paying the account, e.g. parent/guardian, then please complete 'Person Responsible for Payment' section.
- ♦ We may ask for the payment of a deposit prior to admission.

Insurance Prior Approval

Please attach a copy of your prior approval letter from your health insurer or email it to us:

approvals@mercyhospital.org.nz

If your prior approval has not been received then please put 'Pending' in the Approval No. box.

Person Responsible for Payment

Please complete this section if you are paying on behalf of a patient. Then read and sign the agreement below.

Name:

Address:

Telephone number:

Email address:

Relationship to patient:

Agreement

- 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 for, and will pay, all costs incurred in connection with this hospital admission.
- 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 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.

Signature of Patient or Person responsible for payment: **Date:**

Payment Options

We accept payment by the following methods:

- By internet banking to our bank account (our bank details will be shown on your invoice).
- By EFTPOS at our ground floor Reception.
- Via our website, go to www.mercyhospital.org.nz and select the 'Pay Now' tab.
- By cheque made out to Mercy Hospital Dunedin Limited and marked 'Not transferable'.
- By credit card (Mastercard and Visa are accepted)
  - ♦ We no longer collect credit card details—to pay by credit card either use the 'Pay Now' option on our website or select the credit card option at our ground floor Reception EFTPOS terminal.

HEALTH INFORMATION

Health Information & Privacy

We will only give information to people inquiring about you with your permission. Please name those people (if any) that we may give information to while you are in hospital.

Any personal or health information collected from you or your health services provider is collected to ensure you receive the best care and treatment at Mercy Hospital, for quality improvement 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 Mercy Hospital, in order for them to deliver appropriate health services. Your rights provided in the Health Information Privacy Code (1994) and the Privacy Act (1993) will be respected, including 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 at Mercy Hospital.

Language

If you have trouble speaking or understanding English:

Will a family member interpret for you? Yes ☐ No ☐

Would you like us to provide an interpreter for you? (This will be at your own cost). Yes ☐ No ☐

Cultural Needs

Please state any specific cultural needs that you have:

Disability / Special Needs

Please list any special needs or assistance required:

Smoking & Alcohol

Do you smoke cigarettes? Yes ☐ No ☐

Do you vape? Yes ☐ No ☐

Do you smoke e-cigarettes? Yes ☐ No ☐

If 'yes' how many per day?

Do you drink alcohol? Yes ☐ No ☐

If 'yes' how much?

How often?

Mobility / Activity

Mobility (tick which best applies)

Independent ☐ Require assistance ☐

Completely dependant on assistance ☐

My activity is restricted by:

Shortness of breath ☐ Chest pain ☐ No restriction ☐

Fear of falling ☐ Joint pain ☐

How many flights of stairs can you climb without getting short of breath?

One ☐ Two ☐ Three or more ☐

Falls

Have you slipped, tripped or fallen in the last 12 months?

Yes ☐ No ☐ If yes please describe

Implants / Aids

Please tick those that apply to you.

Poor eyesight ☐ Glasses ☐ Contacts ☐

Hearing loss ☐ Hearing aids ☐ Other ☐

Dentures ☐ Top ☐ Bottom ☐

Dental implant ☐ Caps ☐ Crowns ☐

Loose teeth ☐

Joint replacement ☐ Which joint?_____

Other implants Pins ☐ Plates ☐

Other _____ Where _____

Walking aids Frame ☐ Wheelchair ☐

Crutches ☐ Stick ☐

Dietary Allergies / Intolerances

Please tick if you have an **allergy** to the following. (All allergies will be treated as potentially life threatening (anaphylaxis) and totally excluded from your hospital diet).

Egg ☐ Peanuts ☐

Fish ☐ Sesame ☐

Gluten (Coeliac) ☐ Shellfish ☐

Latex ☐ Soy ☐

Lupin ☐ Tree nuts ☐

Milk ☐ Wheat ☐

Other_____

Please tick if you have any of the following **dietary Intolerances** or cultural requirements.

Low FODMAP ☐ No Sulphites ☐

Low Salicylates ☐ Halal ☐

Low Lactose ☐ Vegan ☐

No Colour ☐ Vegetarian ☐

No Preservatives ☐

Other_____

If you have any **food preferences** please communicate these to the food services assistant who will take your meal order.

Health Questionnaire

1a. Your weight ____ kg

1b. Your height ____ cm

2. Do you have or have you ever had any of the following:

a. Chest pain/tightness/angina Yes ☐ No ☐

b. Irregular heart beat/heart murmur Yes ☐ No ☐

c. Previous heart attack Yes ☐ No ☐

d. Heart/Lung surgery/artificial heart valve Yes ☐ No ☐

e. Implanted heart defibrillator/pacemaker Yes ☐ No ☐

f. High blood pressure Yes ☐ No ☐

g. Breathing difficulties/asthma/emphysema Yes ☐ No ☐

h. Persistent cough Yes ☐ No ☐

i. Obstructive sleep apnoea /use CPAP machine Yes ☐ No ☐
(sometimes stop breathing while you are asleep)

j. Stroke or mini-strokes (CVA/TIA) Yes ☐ No ☐

k. Sudden loss of vision/speech/movement Yes ☐ No ☐

l. Blood clots in the legs or lungs Yes ☐ No ☐

m. Bleeding or clotting disorder Yes ☐ No ☐

n. Heartburn/acid reflux Yes ☐ No ☐

o. Diabetes - controlled by diet Yes ☐ No ☐

- controlled by tablets Yes ☐ No ☐

- controlled by insulin Yes ☐ No ☐

p. Kidney condition Yes ☐ No ☐

q. Jaundice or liver condition Yes ☐ No ☐

r. Tuberculosis Yes ☐ No ☐

s. Hepatitis B, C or HIV Yes ☐ No ☐

t. Have you ever been told that you are at risk of Creutzfeldt-Jakob disease (CJD)? Yes ☐ No ☐

u. Problems with jaw opening or neck stiffness Yes ☐ No ☐

v. Skin problems, ulcers, wounds or tears easily Yes ☐ No ☐

w. Dementia e.g. Alzheimer's, memory lapses Yes ☐ No ☐

x. Previous cancer Yes ☐ No ☐

y. Epilepsy/seizures Yes ☐ No ☐

z. Thyroid problems Yes ☐ No ☐

aa. Arthritis Yes ☐ No ☐

3. If you answered yes to any of the above please provide details:

4. Do you have an allergy or have you had a bad reaction to:

Medication Yes ☐ No ☐

Plasters Yes ☐ No ☐

Latex Yes ☐ No ☐

Iodine Yes ☐ No ☐

Chlorhexidine Yes ☐ No ☐

Other substance Yes ☐ No ☐

If Yes please complete:

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

5. Do you wear a medic alert bracelet or carry a medic alert card? Yes ☐ No ☐

6. Please list previous surgeries & heart procedures

Surgery/Procedure	Hospital	Date

7. Please list below all medications & supplements (including herbal remedies) you are taking.

	Strength e.g. 10mg	Number of tablets	How often e.g.3x day

IMPORTANT

- **Please obtain a printout from your GP or pharmacy of all the medications you are currently taking.**
- **Please bring all medications you are currently taking to the hospital when you attend pre-admission clinic and/or on the day of admission.**
- **Please do not bring blister packs/home pill organisers. Medications must be in their original container or box for you to use in hospital. Your GP can help you with this.**

8. Do you or any blood relative have any major illnesses e.g. diabetes, muscular dystrophy, malignant hyperthermia, blood clots in the legs or lungs?

Yes ☐ No ☐ If "yes " please list

9. Have you or any blood relative had problems with an anaesthetic?

Yes ☐ No ☐ If "yes " please outline.

10. Do you have any other condition or disability not covered elsewhere in this form?

Yes ☐ No ☐ If "yes " please outline.

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

Yes ☐ No ☐

12. **Women only**

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

Are you taking a contraceptive pill? Yes ☐ No ☐

Are you taking hormone replacement therapy? Yes ☐ No ☐

DISCHARGE PLANNING

Hospital discharge time is usually between 10am and 11am.

13. Do you live alone? Yes ☐ No ☐

14. Who will care for you on discharge?
You should not be on your own for at least the first 24 hours.
If you have had a joint replacement or other major surgery, you will need someone to stay for several days.
Please provide details of who will be with you following discharge.

15. Do you provide care for other people who live with you?

Yes ☐ No ☐ If Yes please provide details.

16. Do you use any community services?

E.g. meals on wheels, home help, or district nursing

Yes ☐ No ☐ If Yes please provide details.

17. Please provide details of the person who will take you home from hospital.

Legally you are not allowed to drive for 12 hours after a general anaesthetic.

CHECKLIST

Please ensure you have completed each of the following sections:

- ☐ Admission information (page 1)
- ☐ Payment of accounts (page 2)
- ☐ Health information & questionnaire (pages 3,4 & 5)

AND

- ☐ Obtained a printout from your GP or PHARMACY of all medicines your are taking.
- ☐ Completed the information form for pharmacy if you have a community services card.

Please return this form to arrive at least one week prior to your admission date.

Declaration

I certify that all the particulars on this form and the health questionnaire are correct.

Patient Signature _____ Date _____

If this form was completed by someone other than the patient, please write name and relationship to patient below.

Name _____ Relationship to patient _____