Admission Form

ANGLESEA HOSPITAL *taking pride in excellence*

Admission Date: Admission Time:

Nil Per Mouth:

Please complete and post or deliver this form 3-4 days before your admission to:

Anglesea Hospital
Knox Clinic, Knox Street, Hamilton 3204
PO Box 228, Hamilton 3240

PERSONAL INFORMATION

Mr/Mrs/Ms/Miss/Dr

Surname First Name(s)

Preferred Name Date of Birth Age M F

Home Address

Postal Address

Telephone Home Business Mobile

Email

Occupation Ethnicity

General Practitioner Phone

NEXT OF KIN / CONTACT PERSON

Name Relationship

Address

Telephone Home Business Mobile

If you require, or have arranged an interpreter, please complete this section

Interpreter Required? Yes

Name of Interpreter Arranged Language

ALLERGIES

Have you ever had any allergic reaction to medications, iodine, latex, plasters, food or any other substance?
If yes please list your allergies and describe the reactions.

Y ☐ N ☐ _____

_____

MEDICATIONS

List all current medicines, tablets, inhalers, injections, herbal remedies, vitamins and other supplements:

MEDICATIONS/REMEDIES	DOSE	FREQUENCY

PAYMENT DETAILS

Please indicate below how you intend to make payment for your procedure

Medical Insurance Company _____ Approval Number _____

ACC Approval number _____ (personal expenses ie telephone calls excluded)

PERSONAL PAYMENT

I will pay my account by Cheque ☐ Cash ☐ Credit Card ☐ Eftpos ☐

If you selected credit card as your option, please complete and sign:

Card type: Mastercard Visa AMEX

Credit Card Number ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ Expiry Date ☐☐/☐☐

Name on Credit Card ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Signature ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

I understand that signing this credit card authority authorises Anglesea Hospital to debit my credit card with all amounts due and owing the Anglesea Hospital in relation to my admission and treatment at Anglesea Hospital.

I agree to settle my account in full when personally paying my account. I understand I am responsible for any outstanding balance if my procedure is not fully covered by insurance, ACC or other contract.

Name _____ Date _____

Signature _____

Health Questionnaire

TO BE COMPLETED BY THE PATIENT (or patient representative)

HAVE YOU EVER HAD OR DO YOU HAVE: (circle which one)			COMMENTS
Bleeding problems / Anaemia / Bruising / Family History of bleeding problems	Y	N	
Reflux / Hiatus Hernia / Hernia / Heartburn / Indigestion	Y	N	
Heart attack / Angina / Chest Pain / Palpitation / Valve or Pacemaker / Heart Murmur	Y	N	
Rheumatic Fever	Y	N	
Stroke / TIA / Blood clots in legs or lungs	Y	N	
High Blood Pressure / Swollen Ankles	Y	N	
Epilepsy / Severe headaches / Blackouts	Y	N	
Asthma / Wheeziness / Emphysema / Shortness of Breath	Y	N	
Obstructive sleep Apnoea / Snoring	Y	N	
Diabetes: Insulin / Oral Medication / Diet Controlled	Y	N	
Hepatitis A / B / C / Jaundice	Y	N	
HIV / AIDS / risk of exposure to HIV	Y	N	
MRSA / Antibiotic resistant infection	Y	N	
Arthritis. If yes which joints?	Y	N	
Bladder Infections / Kidney Disease	Y	N	
Problems with anaesthetics / Family history of anaesthetic problems / Motion Sickness / Post-Op Nausea / Vomiting	Y	N	
Any other illnesses or conditions not covered above	Y	N	
Previous surgery or admission to another healthcare facility (use extra paper if necessary)	Y	N	
Do you smoke?	Y	N	How many per day?
Do you drink alcohol?	Y	N	How much?
Do you use recreational drugs?	Y	N	What and how often?
Do you believe you are pregnant? (women only)	Y	N	How many months?
Do you have dentures / plate / capped teeth / loose Teeth?	Y	N	
Do you wear glasses / contacts / hearing aid?	Y	N	
Do you have any joint implants?	Y	N	
Do you have any physical, emotional, dietary, spiritual, cultural or communication needs?	Y	N	

Consent Form

THIS SECTION TO BE COMPLETED BY THE SURGEON

Surname _____ First Name(s) _____

Procedure Description _____

_____

_____

Operative side of body: Left ☐ Right ☐ Bilateral ☐ Not Applicable ☐

Surgeon's Name _____

Surgeon's Signature _____ Date _____

THIS SECTION TO BE COMPLETED BY THE PATIENT

I _____ agree to have the above procedure performed on myself / my child _____ and that I have received a satisfactory explanation of the intent, risks and likely outcomes of the procedure and of any related treatment that becomes necessary.
I have had the opportunity to ask questions and may seek more information at any time.

I consent / do not consent to being given blood and blood products should they be deemed necessary.

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 for blood-borne diseases including Hepatitis and HIV. I understand I will be informed of the results if I request them, and any need for further medical referral.

I wish to have my surgically removed body parts returned to me.

Yes ☐ (I understand that in certain circumstances this may not be possible.) NO ☐

Patient / Guardian Signature _____ Date _____

CONSENT TO ANAESTHESIA

I agree to anaesthesia/sedation being given to myself (or my child).
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 may seek more information at any time.

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 anaesthesia.

Patient / Guardian Signature _____ Date _____

Anaesthetist Signature _____ Date _____