Patient Admission Form

Complete all sections and return to Laparoscopy Auckland as soon as possible

It is important that the information supplied to us is accurate and up to date. All personal information obtained by Laparoscopy Auckland is protected under the terms of the Privacy Act 1993. Please contact on (09) 623 8525 if you wish to access or correct any information on this form.

LAPAROSCOPY
AUCKLAND

148 Gillies Ave, Epsom, Auckland
Ph: (09) 623 8525 Fax: (09) 623 8526

Private and Confidential

Patient Information

Please note: This section MUST be completed in full otherwise delays will occur in the booking procedure. PLEASE PRINT.

Surname: _____ ☐ Mr ☐ Ms ☐ Mrs ☐ Miss ☐ Other _____

First names: _____

Date of birth: _____ Age: _____ Place of birth: _____

Gender: ☐ Male ☐ Female

NZ Resident: [Y] [N] Religion: _____

ETHNIC GROUP (for statistical purposes only): _____

Occupation: _____

Residential address: _____

_____

Postal address: _____

Home phone: _____ Business phone: _____ Mobile phone: _____

Email Address: _____ Family doctor (GP): _____

Contact person: _____ Relationship to patient: _____

Address: _____ Phone: _____

Admission Details

Please note: This section MUST be completed in full otherwise delays will occur in the booking procedure. PLEASE PRINT.

Consultant/Surgeon: Mr Adam Bartlett

Date of admission: _____ Time of admission: _____

National Health Index number (if known): _____

Have you been a patient at Laparoscopy Auckland before? [Y] [N] If yes, year: _____

Have you worked/been a patient in a hospital within the last six months? [Y] [N] If yes refer Box A and B.

[A] Hospital / City / Country: _____

[B] Ward: _____

MRSA Required: [Y] [N] VRE Required: [Y] [N] ESBL Required: [Y] [N] Other: [Y] [N]

Overseas Patients

New Zealand contact address: _____

_____

Phone number: _____

Private overseas patients are required to make payment upon admission based on the estimated total cost of your hospital stay.

Please contact Laparoscopy Auckland reception, on (09) 623 8525

If you have medical insurance you will need to obtain prior approval from your approved overseas Medical Insurance company or other Agency prior to admission. To confirm this please ensure your *LETTER OF AUTHORITY* is forwarded to Laparoscopy Auckland prior to admission.

Financial Details

Medical Insurance

If you have medical insurance please contact your Insurance Company to obtain approval *PRIOR* to your hospital admission.
Please note: Any late or non-payment by your Medical Insurance company for your hospital costs is your full responsibility.

Name of Insurance Company: _____

Type of policy and number: _____

Prior Approval number: _____

Please bring your Prior Approval letter with you on admission.

Non-insured Patients

If you have no insurance you will be required, on admission, to pay a deposit equivalent to the estimated cost of the procedure. You will be provided with an estimate of costs by your specialist prior to admission.

I acknowledge this statement:

Signature: _____

Date: _____

Name in full: _____

Payment Details

My payment will be by: ☐ Cash ☐ Cheque ☐ Credit Card ☐ EFT POS (Bank limits may apply)

It may be advisable to pre-arrange financial assistance with a relevant institution to cover the costs of your hospitalisation.

All patients are required to pay for personal expenses such as telephone calls and fax charges.

I understand that Laparoscopy Auckland may notify credit reporting or debt collection agencies should I default in any payment due by me to Laparoscopy Auckland. Ongoing unpaid accounts may incur collection fees.

Payment: Payment of all monies due to Laparoscopy Auckland Ltd ("LAL") are due on discharge or within 7 days of receiving invoice. Interest may be charged at the rate of 3% per calendar month on all overdue accounts, such interest being calculated monthly and payable on demand. All costs incurred by LAL in the collection of overdue accounts are payable on demand. These provisions are without prejudice to any other rights and remedies arising from such default.

Guarantee: In consideration of LAL agreeing to provide medical services at the request of the Guarantor/s to the Patient, the Guarantor/s hereby jointly and severally (where more than one) indemnify and guarantee to LAL payment of all monies owing by the Patient under these terms and conditions and shall pay on demand all monies that at any time are owing by the Patient to LAL. The Guarantor/s agree that liability hereunder will not be affected, avoided or released by any variation or alteration to these terms.

Signed by the Patient: _____ Signed by the Guarantor/s: _____

Date: _____ Contact Details: _____

Date: _____

ACC Claims

Contract Claim If your medical procedure is an ACC Contract Claim ACC will pay the hospital directly for all hospital and specialists' costs, excluding personal expenses.

Individual Claim If your medical procedure is an individual ACC Claim a copy of the ACC Letter of Approval *MUST* be received by Laparoscopy Auckland prior to admission. ACC does *NOT ALWAYS COVER FULL COSTS* of hospitalisation.

A deposit will therefore be required on admission for the estimated difference in costs.

For futher details on ACC reimbursement practices please ask your ACC Case Manager.

ACC Claim number: _____ ACC Office: _____ ACC Case Manager: _____

ACC Case Manager Contact Phone number: _____ Fax number: _____

Laparoscopy Auckland is required by law to retain your clinical records for 10 years.

In the event of destruction of records, do you wish your record to be

☐ returned to you OR ☐ destroyed in accordance with relevant legislation. (Please tick appropriate box)

Personal Information I consent to Laparoscopy Auckland sharing relevant information as required with third parties such as medical insurers, medical consultants and the ACC.

Personal Property I understand and agree that Laparoscopy Auckland 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 acknowledge and understand the Financial Details

Signed: _____ Date: ____/____/____

I accept this contract is covered by New Zealand Law.

Health Information Record

FULL NAME: _____

DATE OF BIRTH: _____

TELEPHONE: _____

(or affix patient label)

Proposed Surgery: _____

Date of Surgery: _____

Do you suffer from or have you ever suffered from the following? *(circle Y for Yes & N for No)*

Chest Pain/tightness or angina	Y	N	Shortness of breath	Y	N	Smoke	Y N
Previous Rheumatic fever	Y	N	Asthma	Y	N	How Many?	_____
Previous Heart Attack	Y	N	Emphysema or Bronchitis	Y	N	Drink Alcohol	Y N
Palpitations	Y	N	Obstructive Sleep Apnoea	Y	N	How Much?	_____
Heart Murmur	Y	N	Stroke or Seizures	Y	N	How Often?	_____
Artificial Heart Valve or Pacemaker	Y	N	Persistant coughs	Y	N	Your Weight?	_____ Kg
High Blood Pressure	Y	N	Infectious Diseases eg. Tuberculosis,	Y	N	Your Height?	_____
Hiatus Hernia/Heartburn/Indigestion	Y	N	Hepatitis, ESBL, VRE, MRSA, HIV			Are you pregnant?	Y N
Diabetes – Insulin Dependent	Y	N	Diabetes – Oral Medication	Y	N	Special Diet	_____
Kidney Disease	Y	N	Thyroid Disease	Y	N		
Rheumatoid Arthritis	Y	N	Previous DVT or Lung Embolus	Y	N		
Bleeding or Clotting Disorder	Y	N	Car/Sea Sickness	Y	N		

If you have answered yes to any of the above, please give further details and list any other health problems below:

_____

_____

_____

What physical activity/ies do you take part in on a regular basis? *(please circle those that apply)*

Walking Gym work Tennis Golf Other (list)

I can climb one / two / or more *(circle)* **flights of stairs without getting short of breath.**

My activity is restricted by *(circle)* Shortness of breath Chest pain Joint pain

Do you have any problems opening your mouth? Y N

Have you been told of previous problems with your airway under anaesthesia? Y N

Do you have *(please circle those that apply)* Dentures Partial plate Capped teeth Loose teeth

Have you or your family had any problems with anaesthetics? Y N

Please outline ALL previous hospital admissions: ☐ **Not hospitalised before**

PREVIOUS HOSPITAL ADMISSIONS (please list)		
Year	**Condition/Procedure**	**Hospital**

CURRENT MEDICATIONS (please list and bring into hospital with you)			Please list any ALLERGIES or REACTION to drugs/medicine, food, latex, plasters.
Medication (including Aspirin & Warfarin & any herbal/alternative medicines)	**Dose/Number**	**How Often**	
☐ **None**			☐ **None known**

Signature: _____ **Date:** ____ / ____ / ____

Consent Form

FULL NAME: _____

DATE OF BIRTH: _____

TELEPHONE: _____

(or affix patient label)

LAPAROSCOPY
AUCKLAND

Please complete and return form to Laparoscopy Auckland prior to admission

Diagnosis:	Surgeon: Mr Adam Bartlett		
	Anaesthetist:		
Procedure/Operation: Daystay: Y N	Body Side:	G/A R/A L/A	Date of Operation:

Doctors Statement:

I certify that I have explained to _____ the implications of the above surgery/treatment.

Surgeon's Signature: _____ Date: ___/___/___

PATIENT AUTHORISATION FOR TREATMENT/SURGERY

I _____ accept the advice of Mr Adam Bartlett

and agree that I have received a reasonable explanation of intent, alternatives, risks and likely outcomes of the operation/treatment of _____

_____

and I request that this be carried out on myself/my _____. 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 directly related to my health care.

During the perioperative period, I agree to all reasonable measures being taken to ensure my well-being and safety.

I consent to the following as explained by my surgeon: (Please tick) Professional Visitors in OR ☐ Video photographs in OR ☐

Patient/Guardian Signature: _____ Date: ___/___/___

Witness Name: _____

Witness Signature: _____ Date: ___/___/___

BLOOD TESTING

If a healthcare worker is directly exposed to my blood or other body fluids, I agree to blood samples being taken. These samples will only be tested to identify such transmissible diseases as are considered of significant risk to the worker. e.g. Hepatitis B, Hepatitis C and HIV

☐ Yes ☐ No

I understand that I will be informed of such testing and the results if the samples are taken.

Signature: _____ Date: ___/___/___

BLOOD PRODUCTS

I understand the risks and benefits of the use of blood products during or after surgery and have had the opportunity to discuss their use.

☐ **I agree** to the administration of blood or blood products in the rare and serious event when this is judged clinically necessary by my anaesthetist and / or surgeon

☐ **I do not agree** to the administration of blood or blood products, under any circumstances, even if my life is in danger.

Signature: _____ Date: ___/___/___

PRE ADMISSION DETAILS/REQUESTS

Special preparations or medications required on admission:

☐