



Manuka Street Trust Hospital

get well sooner

www.manukastreet.org.nz

IMPORTANT: Please complete all sections and both sides of the form and post or fax **10 days prior to surgery or as soon as possible to: Manuka Street Trust Hospital, 36 Manuka Street, Nelson, Fax to: (03) 548 2767 or email to: administration@manukastreet.org.nz**

Patient Label
(office use only)

Personal Details Admission Date Previous Admission to MSTH (year)

Mr/Mrs/Mstr/Miss/Dr

SURNAME

GIVEN NAMES - LIST ALL

Preferred Name Date of Birth Age

KNOWN AS

Address

Telephone: Home Work Mobile

Email Occupation

Surgeon G.P.

Operation

Ethnicity: NZ European / Maori / Other (please state)

Next of Kin / Contacts

1) Name Relationship

Address if different from the above

Telephone: Home Work Mobile

2) Name Relationship

Address if different from the above

Telephone: Home Work Mobile

Treatment been approved by ACC Yes No ACC Claim number

Name of Medical Insurer Pre-approval number

Do you have any special cultural/spiritual requirements? Yes No

If yes, please detail

Do you have any special dietary requirements? No Request

Do you require an interpreter Yes No Language

Do you require an advocate Yes No

Please complete both sides of this form.

Patient signature Date

Health Information Privacy Explanation

Under the provisions of the Health Information Privacy Code 1994 there is a requirement to collect and store information about each patient to help provide good and safe treatment. It is mandatory to send certain health information to other organisations such as the Ministry of Health. Your medical records will be kept secure and will only be accessed by authorised personnel. You as a patient, have right of access to your notes for as long as Manuka Street Trust Hospital stores them. During this time, if you desire, you can update or correct your medical notes. Requests for access to your notes should be made through our Privacy Officer.

On the day of your operation until you are able to receive phone calls, our

reception or nursing staff will provide callers with a general statement regarding your health, unless advised otherwise.

If you do not wish to have any information disclosed about your stay - please inform us on admission.

If for any reason you require to be transferred to another hospital a copy of your notes from Manuka Street Trust Hospital will accompany you. On discharge, and with your permission, a summary of your treatment will be sent to your General Practitioner by your surgeon.

A copy of the Health Information Privacy Code is available for further information if desired.

OFFICE USE ONLY Checked Referred to Dr.

OFFICE USE ONLY
Diet request form completed

Name Signature

Do you regularly take any medications? YES NO

MEDICATIONS. YOU MUST OBTAIN A PRINTED LIST OF ALL YOUR CURRENT MEDICATIONS FROM YOUR GP OR PHARMACIST AND BRING IT WITH YOU FOR ADMISSION (A HAND WRITTEN LIST IS NOT ACCEPTABLE). THIS IS REQUIRED BY LAW. IMPORTANT - If you do not provide this information your surgery may be delayed or cancelled.

- Non prescription medications you regularly take e.g. homeopathic, vitamins etc. will be discussed with you on admission.
- Bring all medications with you on admission in **their original containers with contents clearly identified.**
- Continue taking all prescription medications prior to admission unless advised otherwise.

Have you ever had a problem with anaesthetic: If yes please detail YES NO

Has any member of your family had a problem with anaesthetic: If yes please detail YES NO

Have you ever had any major illnesses, injury, previous anaesthetics or hospital admissions? Please detail YES NO

When was your last anaesthetic? Please detail

Are you allergic to anything? If yes, list and describe reaction (e.g. sensitivity to latex, rash/swelling etc) YES NO

Have you ever had problems with the following:	YES	NO	COMMENTS
Heart disease, e.g. chest pain, rheumatic fever, heart attack, angina, aneurysms	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Bypass, Aortic surgery	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Lung disease e.g. Asthma, breathing problems	<input type="checkbox"/>	<input type="checkbox"/>
Liver disease e.g. jaundice, hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease / urinary problems	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal bruising or bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Anaemia, other blood disorders or family history of blood disorders	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots (legs or lungs)	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Epileptic fits	<input type="checkbox"/>	<input type="checkbox"/>
Migraines or severe headaches	<input type="checkbox"/>	<input type="checkbox"/>
Substance dependency e.g. morphine	<input type="checkbox"/>	<input type="checkbox"/>
HIV or Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>
Stroke, CVA, TIA (Transient Ischaemic Attack)	<input type="checkbox"/>	<input type="checkbox"/>
Dementia	<input type="checkbox"/>	<input type="checkbox"/>
Problems with neck or opening your mouth	<input type="checkbox"/>	<input type="checkbox"/>
Spinal problems (e.g. surgery)	<input type="checkbox"/>	<input type="checkbox"/>
Sleep problems e.g. Apnoea	<input type="checkbox"/>	<input type="checkbox"/>

General questions:	YES	NO	COMMENTS
If your procedure requires the removal of any body parts, would you like them returned?	<input type="checkbox"/>	<input type="checkbox"/>
Could you be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke? If yes, how many per day?	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink alcohol? If yes, average intake per week	<input type="checkbox"/>	<input type="checkbox"/>
Do you have dentures, plates or crowns etc?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been told that you were carrying or infected with MRSA in the past? Refer to MRSA information leaflet.	<input type="checkbox"/>	<input type="checkbox"/>
Have you had close contact (e.g., family member, partner, flatmate) with someone with MRSA in the last 2 years?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been a patient in, or been a support person of a patient (providing physical care) in another hospital or rest home outside of the Nelson Marlborough region or overseas in the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>
Have you worked at another hospital, rest home or other health care agency outside of the Nelson Marlborough region or overseas in the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>

Please complete both sides of this form.