Manuka Street Hospital

Hospital Administration only
(Patient label)

Patient Admission Form

*Please complete all sections and both sides of the form, and return (deliver, scan, or email) at least **3 weeks prior to your admission.** 36 Manuka Street, Nelson 7010 email: administration@manukastreet.org.nz*

Patient Details

Full Legal Name: _____

Preferred name: _____ Title: i.e. Mr, Mrs _____

Date of birth: _____ Age: _____ **NHI (If *known)*** _____

Gender: _____ **Pronouns** *(Optional)*_____

Residential address: _____

Postal address *(If different from above)*: _____

Email address: _____

Telephone: (*Home)* _____ *(Business)* _____ *(Mobile)* _____

Admission Date: _____ **Surgeon:**_____

Operation:_____

Medical Centre / General Practitioner: _____

Which ethnic group do you belong to? Tick the box or boxes which apply to you.

☐ New Zealand European ☐ Māori ☐ Samoan ☐ Cook Island Māori ☐Tongan ☐ Asian ☐Indian

☐ Other (such as Dutch, Japanese, British) Please state: _____

New Zealand resident: ☐ Yes ☐ No If *no, complete the 'Acknowledgement Form: Non-NZ resident'*

Next of Kin / Contact Person

Name: _____ **Relationship to patient:**_____

Address: _____

Telephone: *(Home):* _____ *(Business):* _____ *(Mobile):* _____

Discharge arrangement / Aftercare Consent

Following the procedure, you are not able to drive a vehicle, operate any machinery, take public transport or a taxi.

YOU MUST HAVE SOMEONE TO COLLECT YOU AFTER YOUR PROCEDURE. YOU WILL NEED TO HAVE SOMEONE TO STAY OVERNIGHT WITH YOU, FOR YOUR SAFTEY. Please provide details.

Name: _____ **Relationship to patient:** _____

Address: _____

Telephone: *(Home):* _____ *(Business):* _____ *(Mobile):* _____

Patient confirmation of understanding:

Patient Signature: _____ Date: _____

Please confirm your understanding of the discharge agreement / Aftercare Consent.

Important: Please send this completed form to Manuka Street Hospital 3 weeks prior to your procedure.

Payment Details

How will your procedure be paid for? Tick and complete

☐ **Health insurance** ☐ **ACC** ☐ **Health NZ (Public System)** ☐ **Paid personally** ☐ **Other** _____

Details of health insurance: **Southern Cross Affiliated Provider contract** □

Name of Insurer: _____ Insurance Membership No: _____

Have you obtained "prior approval" for payment? ☐ Yes ☐ No Approval Number: _____

Please provide your prior approval letter in advance

Methods of payment.

I will pay my account by: ☐ EFTPOS ☐ Credit Card ☐ Debit Card ☐ Internet Banking

Internet banking details

Payee: Manuka Street Hospital Bank a/c: 12-3193-0025426-00

Reference: NHI Particulars: Patient Name Code: Date of surgery e.g., 27 Sep 2023

Would you like to receive your invoice via email? ☐ YES ☐ NO

We will send the invoice to the email address you have provided above.

Account Settlement

Payment prior to surgery

You will need to have paid for your surgery 3 days before admission. The amount is based on the estimated cost of the procedure, payable by you not otherwise covered by your insurance, ACC, or Health NZ (Public Health System).
The deposit will be refunded to you if the procedure is cancelled.
Depending on your health insurance policy or plan you may be required to pay an excess (co-payment). This is not covered by insurance, ACC, or Health NZ. (Public Health System).

Please provide your prior approval letter in advance

Agreement

I agree to settle my hospital account in full no more than 30 days after my surgery, when personally paying my account or where I do not have "prior approval" from my insurer. I understand I am responsible for any outstanding balance if my procedure is not fully covered by insurance, ACC, or other contract.
I give permission for Manuka Street Hospital to obtain any information relating to the approval/claim for this admission from the relevant funder(s), and I authorise that person or organisation to disclose such information to Manuka Street Hospital. I accept that, in the event my hospital account is not met, Manuka Street Hospital reserves the right to add all costs of collection to this account.
I give permission to Manuka Street Hospital, or any health professional (such as my medical specialist) involved in my care in relation to this admission to hospital, to access health information about me that is relevant to my treatment (including pre-admission and after discharge), which may be held by Manuka Street Hospital, other health professionals or other health organisations. I understand that other clinical team members such as student nurses and qualified medical trainees may have supervised involvement with my care and that I have the right to decline their presence or contribution to my care delivery.
I understand the admitting Surgeon, Anaesthetist and other Doctors or health professionals using Manuka Street Hospital's facilities are independent and not employees of Manuka Street Hospital with respect to both my treatment, care and account payment. I accept that this agreement is covered by New Zealand law. The details above have been completed by

Name: _____ **Date:** _____

Signature: _____

If not the patient, state relationship to patient: _____

Important: Please send this completed form to Manuka Street Hospital. Please return deliver, scan, or Email at least 3 weeks prior to your admission or as soon as possible to: Manuka Street Hospital, 36 Manuka Street, Nelson 7010. or email to: administration@manukastreet.org.nz. If you post the form, please allow 1-2 extra weeks for delivery.
Manuka Street Hospital

Hospital Administration only

(Patient label)

Manuka Street Hospital

Patient Health Questionnaire

IMPORTANT: Please complete all sections of the form at least 3 weeks prior to your admission. You can: hand deliver, post (Manuka Street Hospital 36 Manuka Street, Nelson 7010) or complete these on-line by saving a copy to your computer first then email back) Alternatively, you can print out the PDF version to complete manually and email it back to administration@ manukastreet.org.nz.

Please complete this questionnaire carefully as the information you supply helps us to provide you with the best and safest possible care during your stay at our hospital. The questionnaire has four sections:

A Your general health
B In preparation for your hospital admission
C In preparation for your procedure
D Your current medicines

We have endeavored to provide enough space in each area. However, If there is not enough room to list or explain, please add in your email, or if posting - add to a separate sheet.

Surname (family name)

_____

First name (s)

_____

Height **Weight**

_____metres _____kilograms

To support your ongoing care, your discharge information will be sent to your nominated GP.
If you do NOT want this, please tick ☐

Hospital Administration only
(Patient label)

Surgeon _____

NHI (if known) _____

Occupation (optional) _____

All questions in this questionnaire are about the person being treated at the hospital (the patient). If you are filling this out for the patient, only provide information relating to the patient's health.

Section A. Your General Health

A1. MEDICAL PROCEDURE HEALTH ALERT **Do any of the following apply to you?**

Q.	Yes	No		*If Yes*
1	☐	☐	Difficulty climbing more than a flight of stairs	*What restrictes this activity*
2	☐	☐	Jaw problems *(difficulty opening mouth)*	*Specify:*
3	☐	☐	Problems with previous anaesethic	*Specify:*
4	☐	☐	Family history of problems with anaesthetic	*Specify:*
5	☐	☐	Pacemaker or heart valve replacement	*Specify:*
6	☐	☐	Breastfeeding	*Specify:*
7	☐	☐	Implants or prostheses	*Specify:*
8	☐	☐	Substance use or dependency	*Specify:*
9	☐	☐	Former smoker (including e-cigarettes and vapes)	*When did you give up?*
10	☐	☐	Currently on smoking cessation treatment	*Specify:*
11	☐	☐	Current smoker (including e-cigarettes and vapes)	*How many per day?*
12	☐	☐	Pregnant or possibly pregnant	*Aproximate due date:*
13	☐	☐	MedicAlert bracelet or necklace wearer	*Specify*
14	☐	☐	Blood Clots: Deep vein thrombosis (DVT), Pulmonary embolus (PE)	*Specify:*
15	☐	☐	Family history of blood clots	*Specify:*
16	☐	☐	Family history of blood and bleeding conditions	*Specify:*
17	☐	☐	Blood and bleeding conditions	*Select one:* ☐ *Anaemia* ☐ *Bruising*

Hospital Administration only
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Section A. Your General Health *(continued)*

A1. YOUR MEDICAL CONDITION

Do you currently have, or have you previously had, any of the following conditions?
If yes, please select any of the specific conditions that affect you.

Q.	Yes	No	
18	☐	☐	**Breathing conditions:** ☐ asthma ☐ wheeziness ☐ shortness of breath ☐ bronchitis ☐ croup ☐ emphysema ☐ COPD
19	☐	☐	**Sleeping conditions:** ☐ sleeplessness ☐ severe snoring ☐ obstructive sleep apnoea ☐ CPAP used
20	☐	☐	**Heart conditions:** ☐ palpitations ☐ irregular heart beat ☐ heart murmur ☐ angina ☐ heart attack ☐ chest pain ☐ congestive heart failure ☐ rheumatic fever
21	☐	☐	**Stroke or Transient Ischaemic Attack (TIA)**
22	☐	☐	**High blood pressure or blood pressure controlled with medication**
23	☐	☐	**Motion Sickness:** ☐ Mild ☐ Moderate ☐ Severe
24	☐	☐	**Stomach and digestive conditions:** ☐ indigestion ☐ heartburn ☐ acid reflux ☐ hiatus hernia ☐ peptic ulcer
25	☐	☐	**Bowel conditions:** ☐ irritable bowel syndrome ☐ constipation ☐ bowel disease
26	☐	☐	**Liver disease:** ☐ jaundice ☐ hepatitis
27	☐	☐	**Kidney conditions**
28	☐	☐	**Diabetes:** ☐ requiring insulin ☐ requiring tablets ☐ diet controlled
29	☐	☐	**Thyroid conditions**
30	☐	☐	**Parkinson's disease**
31	☐	☐	Neurology: ☐ Epilepsy ☐ seizures ☐ blackouts ☐ fainting
32	☐	☐	**Migraines or severe headaches**
33	☐	☐	**Alzheimers or dementia**
34	☐	☐	**Mental function conditions:** ☐ head injury ☐ concussion ☐ confusion ☐ disorientation
35	☐	☐	**Mental health conditions:** ☐ depression ☐ asperger's ☐ ADHD ☐ other
36	☐	☐	**Emotional conditions:** ☐ anxiety ☐ phobia ☐ post traumatic stress disorder (PTSD)
37	☐	☐	**Arthritis**
38	☐	☐	**Neck or back conditions**
39	☐	☐	**Gum or dental health conditions**
40	☐	☐	**Tuberculosis (TB)**
41	☐	☐	**HIV or AIDS**
42	☐	☐	**Infection or treatment for resistant organisms:** ☐ MRSA ☐ ESBL ☐ VRE ☐ other
43	☐	☐	**Cancer** – *If Yes, please specify and provide details of any recent treatment in the comments box below*
44	☐	☐	**Other condition(s) not listed above** – *If Yes, please specify in the comments box below*

RE QUESTION	YOUR COMMENT
19	*--- example --- GP says my blood pressure is slightly high, but am not taking any medicine.*

Need more space for your comments? Please continue on a separate sheet and attach it to this page.

Surname (family name)

_____

First name (s)

_____

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Section B. In Preparation For Your Hospital Admission

B1. YOUR ALLERGIES, SENSITIVITIES, OR INTOLERANCES

Q.	Yes	No		
45	☐	☐	**Are you allergic to latex?**	
46	☐	☐	**Do you have any other allergies, sensitivities or intolerances?** *If **yes**, please specify and describe the reaction using the box below*	
			Item	**Reaction**
Skin-rerlated			*-- example -- Plasters*	*-- example -- Rash*
Medicine-related				
Food-related				
Other				

B2. YOUR NEEDS AND PREFERENCES

Please answer these questions to help us to tailor how we carefor you.
*If you answer **yes** to any of the quastions, we may contact you to discuss your specific needs.*

Q.	Yes	No		*If **Yes***
47	☐	☐	Do you have a **disability?**	*Specify:*
48	☐	☐	Do you have **difficulty understanding English?**	*Your preferred language:*
49	☐	☐	Do you have any **religious or spiritual needs** you would like us to know about?	*Specify:*
50	☐	☐	Do you have any **cultural or family needs** you would like us to know about?	*Specify:*
51	☐	☐	Do you have any **other special needs** you would like us to know about?	*Specify:*
52	☐	☐	If your procedure requires the **removal of body parts,** would you like them returned to you if this is possible?	
53	☐	☐	**Do you have any dietary requirements?** ☐ vegetarian ☐ vegan ☐ diabetic ☐ halal ☐ dairy free ☐ gluten free ☐ other _____	
54	☐	☐	Do you have any **specific food dislikes?** *For allergies or intolerances, refer to question **46***	*Specify:*

Hospital Administration only
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Section C. In Preparation For Your Prcedure

C1. MEDICAL PROCEDURE HISTORY

Q.	Yes	No	
55	☐	☐	**Have you previously had any procedures / operations or other hospital admissions?** *If Yes, please outline your previous admissions in the table below. If you need more space, please continue on a separate sheet and attach it to this page.*

Procedure or event	Year	Hospital

C2. ANAESTHESIA CONSIDERATIONS

Q.	Yes	No		*If Yes*
56	☐	☐	**Have you had an anaesthetic before?**	☐ general ☐ spinal ☐ epidural ☐ unsure
57	☐	☐	**Do you have any of these dental features?**	☐ upper denture ☐ lower denture ☐ crown(s)/cap(s) ☐ partial plate ☐ loose or chipped teeth
58	☐	☐	**Do you drink alcohol?**	*How much?*

C3. PERSONAL ITEMS

Do you use any of these personal items?

Q.	Yes	No		
59	☐	☐	**Mobility aids, such as a walking stick or cane**	*Specify:*
60	☐	☐	**Hearing aids, Glasses or contact lenses**	*Specify:*

C4. BLOOD CLOT AND INFECTION CONSIDERATIONS

Q.	Yes	No	
61	☐	☐	Have you recently been on a **long distance flight**? *If Yes when?* _____
62	☐	☐	In the past 3 days, have you had, or been in contact with anyone who has had, **vomiting or diarrhoea**?
63	☐	☐	In the past 7 days, have you experienced **flu-like symptoms**, or been in contact with anyone diagnosed with **influenza**?
64	☐	☐	In the past 4 weeks, have you had a **head cold, throat or chest infection, or bronchitis**?
65	☐	☐	In the past 12 months, have you **travelled overseas**? If Yes, specify tyhe country _____
66	☐	☐	In the past 12 months, have you been a patient or employee in a hospital or resthome in **New Zealand or overseas**?
67	☐	☐	Do you have any **boils, cuts, sores, scratches or other skin or urine infections**? If Yes, specify _____
68	☐	☐	Have you had **Covid-19**? *If yes, when state the last occurrence:* _____

C5. OTHER CONCERNS

Q.	Yes	No	
69	☐	☐	**Is there anything we need to know that you prefer not to write on this questionnaire?** *– If Yes, please discuss with your nurse or medical specialist when you arrive at the hospital.*
70	☐	☐	**Do you have anxieties, concerns, or questions you wish to discuss before your procedure?** – If Yes, who would you like to speak with? ☐ your surgeon ☐ your anaesthetist ☐ a nurse ☐ admin staff

Surname (family name) _____

First name (s) _____

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Section D. Your Current Medicines

For your safety, it is extremely important that your doctors and nurses know precisely which medicines you are currently using.

Important instructions.

1. List below all medicines you currently use, and bring them with you to the hospital in their original containers
2. To ensure you are clear what to include, please use the **MEDICINE REMINDERS** table (right →)
3. If you have a medication card or printout from your GP or pharmacist, please bring it with you to the hospital, as well as completing the list below.

MEDICINE REMINDERS
Which of the examples below apply to you?

There are many **types** of medicine		Medicines come in many **forms**		Medicines are taken for many **common conditions**	
prescription medicines	*vitamins*	*tablets*	*patches*	*heart disease*	*infections*
herbal medicines	*supplements*	*capsules*	*suppositories*	*high blood pressure*	*diabetes*
natural medicines	*contraceptives*	*inhalers*	*creams*	*blood thinning*	*sleeplessness*
homeopathic remedies	*steroids*	*drops*	*injections*	*dietary deficiencies*	*epilepsy*
over-the-counter medicines		*syrups*	*other liquids*	*emotional conditions*	

D1. YOUR CURRENT MEDICINES

Patient to complete - last all medicines you currently use.

Name of medicine	**Strength**	**How much you use and when**
Example - Paracetamol	*500mg*	*2 capsules every 6 hours*

If requited please continue on the reverse

HOSPITAL USE ONLY

Reconciled: Yes **(Y)** | No **(N)** | Not available **(NA)**					
Medicine container	*Medication card*	*Patient or whānau/ family*	*Other (state) eg, 'phoned GP'*	*Comment if No*	*ON ADMISSION Date/time last taken*
–	–	–	–	–	–

This is not a prescription or an instruction to administer medicines

Hospital Administration only
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Section D. Your Current Medicines *(continues)*

Continued from reverse

D1. YOUR CURRENT MEDICINES		
Patient to complete - last all medicines you currently use.		
Name of medicine	**Strength**	**How much you use and when**
Example - Paracetamol	*500mg*	*2 capsules every 6 hours*

HOSPITAL USE ONLY					
Reconciled: Yes **(Y)** | No **(N)** | Not available **(NA)**					
Medicine container	*Medication card*	*Patient or whānau/ family*	*Other (state) eg, 'phoned GP'*	Comment if No	*ON ADMISSION Date/time last taken*
–	–	–	–	–	–

This is not a prescription or an instruction to administer medicines