

fortéhealth

**PATIENT INFORMATION
& ADMISSION FORMS**



WELCOME TO FORTÉ HEALTH

At Forté Hospital we are committed to making your stay as comfortable as possible. Our pledge to you is simple - we take pride in providing expert, caring service that focuses on your individual needs. To do this we need your help to provide the clearest information so we can offer the greatest level of care.

Therefore we need you to take the time to read this information pack carefully and complete all sections fully. Where possible please make sure these forms reach us no later than five (5) business days before your admission. Post (this may take up to 5 working days), fax or deposit in our letterbox at the front entrance. If you have any questions please don't hesitate to get in touch (contact details are on inside back cover).

YOUR ADMISSION INFORMATION

DATE OF ADMISSION

..... Arrive at AM PM

FASTING INSTRUCTIONS

Do Not Eat After AM PM On

Stop All Clear Fluids From AM PM On

MEDICATION INSTRUCTIONS

Take All Usual Medications Yes No

If **NO**, what medications should I **NOT** take?

OTHER INSTRUCTIONS

YOUR ADMISSION FORMS

THESE ARE AT THE BACK OF THIS FOLDER AND NEED TO BE FILLED IN PRIOR TO ADMISSION.

YOUR CHECKLIST, IT'S TIME TO TICK THE BOXES

In the lead-up to any procedure there's probably a lot on your mind, and it's easy to forget an important detail. That's why we recommend taking the time to check the boxes as you complete each task and pack each item.

TO DO

Complete and sign all forms found at the back of this booklet, and return at least 5 business days prior to your admission.

- Registration Form
- Patient Health Questionnaire
- Payment of your Hospital Account Form
- Agreement to Treatment Form
- Medicine Reconciliation (Medicine List)

If necessary, contact your insurance company for 'prior approval' for the procedure and obtain written confirmation of approval and supply a copy to us prior to your procedure.

Stop eating and drinking according to the instructions of your surgeon.

Complete any additional requirements according to instructions.

Remove all nail polish or false nails from hands and feet.

Arrange private transport (not a taxi or bus) to take you home from the hospital.

Arrange for someone responsible to look after you following your discharge.

TO BRING

Your insurance company 'prior approval' letter.

All current medications - even if you have been instructed not to take them before your procedure.

A printed list from your GP or pharmacist of your current medication prescriptions with the dose and frequency of each drug and who prescribed it. You can attach to your admission form, fax, email or bring to us.

Any glasses, hearing or walking aids you require.

Your medic alert bracelet (if you have one).

PLEASE NOTE:

One of our hospital staff will ring you the day before your surgery to discuss your arrival time and answer any questions you may have.





ABOUT FORTÉ HOSPITAL

A NEW STANDARD OF CARE.

Forté Hospital has been designed by healthcare professionals with a focus on improving the patient's experience. We will provide quality and efficient patient care in a calm and contemporary environment.

Our building is the first in New Zealand to utilise the PRESSS frame technology which provides structural strength and stability at 180% of the building code. This creates a safe environment for patients, clinicians, staff and visitors.

We have made a genuine commitment to environmental sustainability by implementing Green features in our design and as a result is the first hospital building in New Zealand to have a Green Star Rating.

MISSION STATEMENT

We are committed to health. We will be the first choice provider for Medical Specialists. We believe in a fresh approach to care – for our patients, and employees and will ensure that healthcare is delivered in a sustainable way for the planet.



PERFORMANCE



PERSON CENTERED



TEAMWORK



INNOVATIVE



INTEGRITY



SUSTAINABLE

WE ARE COMMITTED TO

- Providing unparalleled care before, during and after your procedure or surgery.
- Ensuring that your stay with us is as relaxing and as comfortable as possible.
- Keeping you informed regarding your surgery at all times and answering any questions you may have along the way.
- Allowing visitors access at appropriate times and for a duration that suits our patients.
- Discharging you when we are satisfied that it is safe for you to go home.



PREPARING FOR ADMISSION AND DISCHARGE

EVERY DETAIL AND EVERY CARE.

PRIOR TO ADMISSION

Before your procedure ensure you have the following information:

- The procedure or surgery you are consenting to.
- Any further tests and investigations required.
- Any special preparation that's required.
- When you'll need to stop eating and drinking before admission.
- Whether your regular medications and natural remedies should be taken as usual.
- Any symptoms that may postpone surgery.

ARRANGE PAYMENT

If you are paying any part of the cost of this operation yourself please contact accounts on 03 365 8333 or email patient.accounts@fortehealth.co.nz to obtain an indication of the cost and arrange your payment prior to admission.

Please note that the Hospital will give you an approximation based on known average costs. Approximations will be as accurate as possible but the actual cost of any operation can vary significantly if your surgery is more, or less, complex than anticipated.

METHODS FOR PAYMENT OF YOUR ACCOUNT

Cheque, Cash, EFTPOS or Credit Card *[Visa & Mastercard accepted]*. Please pay at Forté Health reception.

Internet Banking, please make the payment to the following account:

Forté Health Limited; Account number: 12-3191-0032331-00 and use your invoice number and full name as a reference.

PLANNING FOR YOUR DISCHARGE

Home Care: If you live alone it's important you arrange for a responsible adult to stay with you for at least 24 hours following your discharge.

Driving: If your procedure or surgery involves a general anaesthetic or sedation you must **NOT** drive for 24 hours following surgery. For some procedures you may not be able to drive until your surgeon has informed you it is safe to do so.

Post surgery: Please ensure there's a responsible adult to collect you at time of discharge.

Discharge: Is usually 10am the day following surgery. Special arrangements can be made if required so please contact us.



DURING ADMISSION

YOUR JOURNEY. OUR GUIDANCE.

WHAT TO BRING (OR NOT BRING)

Clothing: Bring personal effects and wear comfortable loose-fitting clothing that is easy to change in and out of. During your stay we'll provide you with a gown until you're ready to change back into your clothes for the trip home.

Personal aids: Bring contact lenses, glasses, hearing aids, dentures, walking aids and any other special equipment (including personal headphones if preferred) you may require during your stay.

Toiletries: If expecting to stay overnight please bring personal toiletries. **NB: We have limited storage facilities for large pieces of luggage.**

Makeup and jewellery: Please wear as little makeup as possible and **remove nail polish, acrylic, gel nails, shellac nails**, jewellery and piercings.

Valuables: Please leave all valuables (including jewellery and cash) at home.

Medications: You must bring a printed statement from your GP or pharmacist of your current medication prescriptions with the dose and frequency of each drug and who prescribed it. This is a mandatory requirement. Your surgeon will give you information regarding which medications you will need to take prior to the procedure. Bring your current medication in the original packaging.

Section 29 Medications: Your medical specialist may administer some medications during your procedure which are known as "Section 29" medications. Section 29 medications are effective and safe and are approved in other countries, but may not be approved for use in NZ, however may be used in the course of your treatment. If so your medical specialist will discuss this with you and provide appropriate information.

WHERE TO GO AND WHAT TO DO

Parking: We provide limited on-site parking. The car park entrance is located on Peterborough Street.

On arrival: Please go to the Forté Hospital reception on the ground floor. From there your admission process and preparation for theatre will commence.

Karakia: If you would like a Karakia performed during your admission, please advise us of the arrangements you have made. We can assist with this – simply contact the hospital receptionist for further guidance.

Bringing support: You are welcome to bring friends or family to stay with you until the time of your admission.

Nursing assistance: A member of our nursing staff will admit and prepare you for the procedure. Be sure to let them know if you have any particular cultural, spiritual, social or emotional needs. Your nurse can also answer any questions and address any concerns – now's a good time to ask.



TREATMENT AND DISCHARGE

GETTING THROUGH. GOING HOME.

Talking it over: Your anaesthetist and your surgeon will see you before your procedure or surgery to ensure everything is on track.

After the procedure: Following your procedure you will be taken to the recovery area and, if you're staying overnight, will be transferred to our ward. For patients going home the same day of the procedure, you will go to the Day Stay Lounge where you can change into your own clothes and go home once a nurse and medical surgeon has assessed you as ready for discharge. We can also call your contact person so they can pick you up when it is safe to do so.

Visiting Hours: Visitors are most welcome, however in some instances restrictions may apply. We advise visitors to call us beforehand to arrange a suitable visiting time. A Whanau room for family is also available upon request. We prefer visitors to leave by 9pm to allow time for our patients to settle for the night.

Ringing the Hospital: If you want to ring us after hours, please call **03 365 8333**.

After you have been discharged: If for any reason you become unwell or have any concerns regarding your surgery and you have been discharged from the hospital, please refer to your discharge information for your surgeons contact details, or in the event of an **emergency dial 111**.

DISCHARGE

Prior to discharge you will be given:

- A discharge summary with all the relevant information of your procedure.
- An information sheet to help answer any questions you may have following your procedure.
- You may also be provided with a prescription and/or medications, and any relevant instructions or information relating to these.

A follow up appointment to see your surgeon will also be discussed now. If you need further assistance following your discharge please phone your surgeon or practice nurse. We take pride in our post-care support and are always ready to assist during this time.



SURGERY FOR CHILDREN

INFORMATION AND ADVICE

It is never easy when your child is undergoing a procedure. At FHL, the experience and skill of our staff will ensure your child has every possible care and attention. The information below may help guide you how best to support your child before, during and after their procedure.

Before: To help reduce any anxiety in children, it is important to give them information at a level they can understand but without too much detail that it will cause concern. If you have any questions about how to best achieve this please contact us.

During: Hospital admissions can be a testing time for children and their parents. It is helpful to bring your child's favourite toys or books to keep them entertained during their stay, which may involve wait time before the procedure. You will be able to stay with your child at the start of their anaesthetic if you wish and will have the opportunity to discuss this with your anaesthetist and surgeon on the day of admission.

On the day of surgery, the focus will be on your child who is having the procedure so other distractions should be avoided. We advise that you do not bring in siblings unless you have someone with you who can care for them while your child is being admitted or during the initial post-operative time in recovery.

After: With your support, your child will recover more quickly and we aim to reunite parents or carers with their child as soon as possible. This will happen in our recovery room and you will be taken into this area as soon as possible. Please be aware, siblings cannot be taken into the recovery room as this is a restricted area.

Overnight stays: We encourage a parent or carer to stay with their child overnight and will aim to provide a bed in their room, if this is not possible, a lazyboy chair will be provided. You will receive refreshments, an evening meal and breakfast while staying with your child. There is an additional charge for a parent or carer to board. Please note, that we can only safely accommodate one parent or carer to stay overnight.

Day stay: If your child is to be a day stay patient, the length of time that they are with us will depend on your child's recovery and their individual needs.

Special requirements: Please advise us of any special dietary needs for your child well in advance so we can make arrangements with our caterers for post-operative snacks or meals. If your child requires formula or drinking cup/baby bottle, please bring this with you. In addition if your child requires nappies, we have a limited selection of sizes available so you may prefer to bring your own as it is not possible for us to stock the wide range of needs for different age groups.

Our staff are very experienced and committed to ensuring that all children have a positive experience at FHL and do not hesitate to ask us if you have any queries.



FURTHER INFORMATION

HOSPITAL POLICIES AND YOUR FEEDBACK.

YOUR PRIVACY AND CONFIDENTIALITY

All the information and personal data gathered for your visit is to assist in your treatment, for quality assurance activities and to fulfil legislative requirements.

Your rights in the Health Information Privacy Code and the Privacy Act 1993 will be respected, including the right to access and, if necessary, correct any information held about you. If you have any concerns in this regard, please contact our General Manager on 03 365 8333.

STAYING SMOKE-FREE

In the interests of both your health and that of others we have a smoke-free policy. Please respect this and refrain from smoking within the building and grounds.

HELP US TO HELP YOU

The feedback we receive is of immense value – it's how we can continually look to improve our service. The patient survey provided at the time of discharge helps deliver this vital feedback. Please take the time to complete and return this to us. Should you have any complaints, concerns or compliments either during or following your stay please contact our Clinical Services Manager or General Manager on 03 365 8333.

ANY UNANSWERED QUESTIONS?

Further information is available on our website www.fortehealth.co.nz. Should you have any questions or concerns please don't hesitate to discuss this with your nurse or specialist's.

Remember – we're always ready to help. We wish to ensure you have all the necessary information required. If anything remains unanswered please contact the hospital on 03 365 8333.



CONTACT DETAILS

WHERE TO FIND US AND HOW TO CONTACT US.

Forté Health is located in the Peterborough Village area, it is within walking distance of local attractions including Victoria Street, Victoria Square, New Regent Street.

Street Address

132 Peterborough Street,
Christchurch 8013

Postal Address

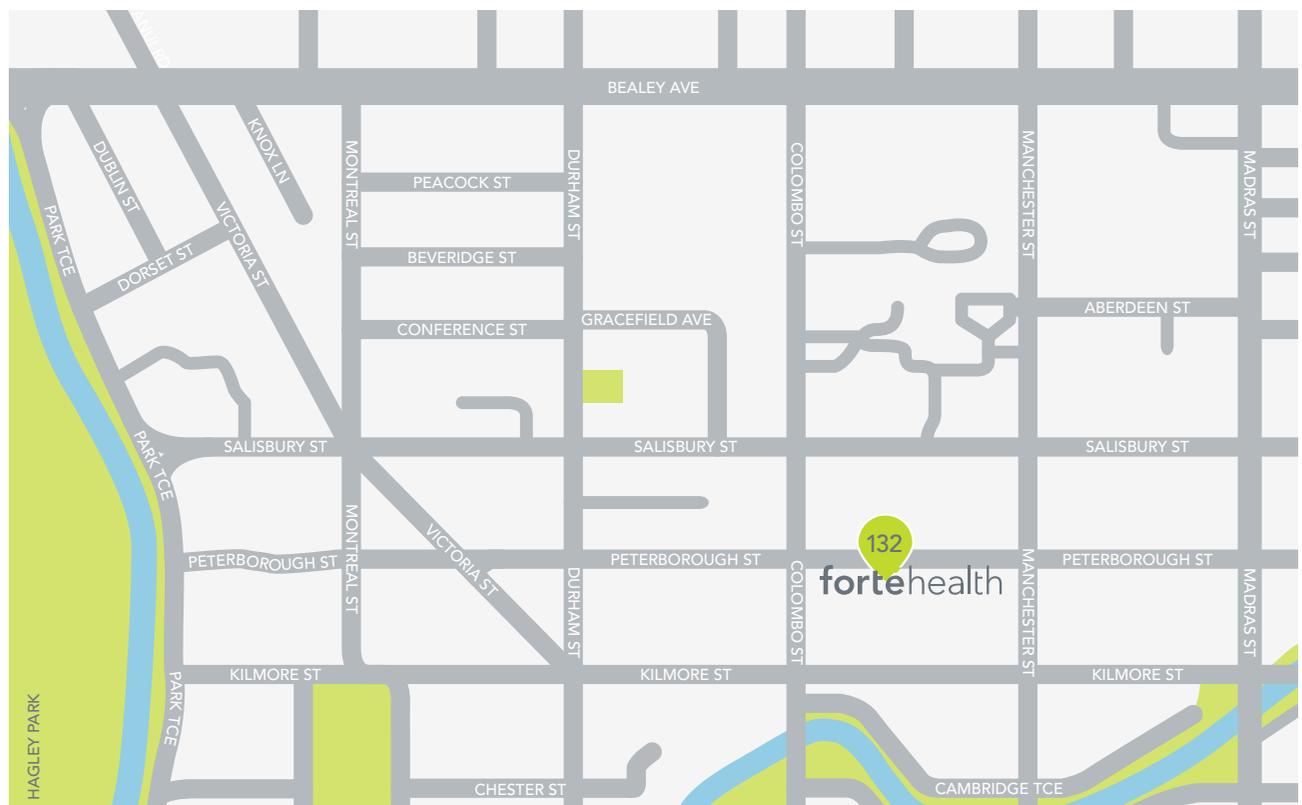
PO Box 1006,
Christchurch 8140

Phone / Fax

Phone 03 365 8333
Fax 03 365 8334

Email / Website

reception@fortehealth.co.nz
www.fortehealth.co.nz



A low-angle photograph of a modern building facade. The building features large, light-colored rectangular panels and glass windows with dark frames. The sky is a clear, bright blue. In the foreground, the word "fortenthealth" is displayed in large, white, 3D block letters on a dark, horizontal surface. The letters are slightly shadowed, giving them a three-dimensional appearance. The "e" in "ent" has a small yellow square on its top surface.

fortenthealth



MEDICAL FORMS

ONLY WITH THE CLEAREST INFORMATION CAN WE OFFER THE GREATEST LEVEL OF CARE.

WHY ARE THE FORMS SO IMPORTANT?

These forms include essential information and important questions about your health history, personal and contact details, consent for treatments and payment arrangements. They also include details of any special needs you may have (which may range from dietary to mobility to cultural and spiritual). If you have any questions about how to fill them out please don't hesitate to get in touch.

- Agreement to Treatment Form (which details the procedure or surgery and your consent for this)
- Anaesthesia Consent Form (if anaesthesia is required)
- Hospital Registration Form
- Payment of your Hospital Account Form
- Patient Health Questionnaire

Your completed forms need to be sent to us as soon as possible, but no later than five days prior to your admission.

POST

Please remove completed forms from your Patient Information book and post to the Hospital at Forté Health, PO Box 1006, Christchurch 8140 (please allow up to 5 working days).

HAND-DELIVER

You can remove completed forms from your Patient Information book and hand-deliver to the Hospital at 132 Peterborough St, Christchurch or deposit in the letterbox at the front entrance.

FAX

Please remove completed forms from your Patient Information book and fax to the Hospital: 03 365 8334. **Please ensure to bring original copies with you upon admission.**

EMAIL

Scan and email to reception@fortehealth.co.nz, **please ensure to bring original copies with you upon admission.** If you have any questions don't hesitate to get in touch.

Surname
First Names
Date of Birth NHI #



Phone 03 365 8333
Fax 03 365 8334
reception@fortehealth.co.nz
132 Peterborough St
PO Box 1006
Christchurch 8140
www.fortehealth.co.nz

REQUEST FOR TREATMENT BY OPERATION/PROCEDURE

THIS SECTION IS COMPLETED BY THE ADMITTING SPECIALIST

PROVISIONAL DIAGNOSIS/REASON FOR TREATMENT:

.....
OPERATION / PROCEDURE:

OPERATIVE SIDE OF THE BODY:

Left Right Bilateral Not Applicable

SEDATION / ANAESTHESIA / PROPOSED ANAESTHESIA:

Local General Sedation Regional Block

ADMISSION DETAILS:

Admission Date Procedure/Surgery Date
Anticipated Length of Stay Hours Days Nights

ADMITTING SPECIALISTS INSTRUCTIONS:

.....
.....

RISKS:

.....
.....

CONFIRMATION OF CONSENT (TO BE COMPLETED BY A HEALTH PROFESSIONAL ONLY)

I have confirmed with the patient or the person legally entitled to consent for the patient, that they have received the information about the operation/procedure/treatment as set out above, have no further questions, and wish the operation/procedure/treatment set out above to go ahead.

SPECIALIST
SIGN HERE

SIGNATURE

Date

Name (PRINT).....

Position

THIS SECTION IS COMPLETED BY THE PATIENT (OR PARENT/GUARDIAN)

Name Home Phone

Address Work Phone

..... Mobile Phone

If you are not the patient, please state your relationship to the patient:

If applicable please attach evidence of your enduring power of attorney for care and welfare.

IMPORTANT NOTES: (TICK IF APPLICABLE)

See also advance directive

See also Enduring Power of Attorney for personal care and welfare documentation

REQUEST FOR TREATMENT BY OPERATION/PROCEDURE

CONSENT TO PROPOSED OPERATION/PROCEDURE/TREATMENT

- I,.....[name of patient or person legally entitled to consent for the patient i.e. parent/guardian, Enduring Power of Attorney for personal care and welfare or Welfare Guardian], request and agree that the operation/procedure/treatment described above be performed on,
..... (name of patient).
- I confirm that I have received a satisfactory explanation of:
 - My/the patient's condition and the options for treating my/the patient's condition; and
 - the operation/procedure/treatment agreed to be performed (as set out above) and the risks, benefits, side-effects, costs and expected time within which it will take.
- I have been told about additional procedures which may become necessary during the operation/procedure/treatment as described above. I consent to these procedures/treatment. I understand that any further procedures in addition to the procedures described above will only be carried out if it is necessary to save my/the patient's life or prevent serious harm to my/the patient's health. This includes complications that may result in a return to theatre.
- I have been provided with information in relation to the administration of blood or blood products, including the risks, benefits, side effects and any costs associated with receiving blood or blood products.
- I consent to myself/the patient receiving any blood or blood products that may be required: Yes No (tick one)
- I agree to anaesthesia/sedation.
- I understand that I may receive Section 29 medications about which I will receive information post-operatively.
- I agree to blood samples being taken and tested should a member of the healthcare team be directly exposed to my/the patient's blood or other bodily fluids. I understand that I will be informed that a sample has been taken and that the purpose of the sample is to test for transmissible diseases as are considered a significant risk e.g. Hepatitis and HIV. I understand that I will be informed of the results of any tests and any need for further medical referral. I understand I can decline to be informed of the results of the test if I do not want to know the results. The results of these tests are confidential to me, and to the extent it is necessary, the health professionals involved in my care.
- I confirm I have had an opportunity to ask questions about the operation/procedure/treatment, any additional procedures or treatment that may be required, the use of blood or blood products (delete if not applicable), and the taking of a blood sample in the event of exposure to my/the patient's blood and my questions have been answered to my satisfaction and understanding. I understand that I may seek more information at any time.

ACCESS, USE AND DISCLOSURE OF MY/THE PATIENT'S HEALTH INFORMATION

- I understand Forte Health, the admitting specialist, and any health professional(s) involved in my care may access health information about me that is relevant to my current admission and treatment, which may be held by Forte Health, the admitting specialist, other health professionals, or other healthcare providers.
- I understand that Forte Health and/or any health professionals involved in my care will collect and store information about me, including my health information and images (including photos, videos, or x-rays during my treatment).
- I understand that any information documented, Including photographs or recordings taken during my admission will be stored in my clinical file and may be referred to for clinical purposes, and/or audit, and/or teaching, and/or research purposes (delete any that do not apply, or you do not agree to).
- I understand that all information held by Forte Health will be kept securely.
- I am aware that I can request more information and ask any questions about Forte Health's Privacy Policy and how information is collected, stored, used or disclosed by Forte Health at any time.
- I have read and understood the above information:

SIGN
HERE

SIGNATURE Date

[By patient or parent / guardian if patient is under 16]

DETAILS OF GUARDIAN IF SIGNING ON BEHALF OF THE PATIENT:

SIGN
HERE

SIGNATURE Date.....

Name(PRINT)..... Authority to consent if not the patient*.....

(* i.e. parent/guardian, Enduring Power of Attorney for personal care or welfare, Welfare Guardian)

Surname
First Names
Date of Birth NHI #



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ANAESTHESIA CONSENT FORM

THIS SECTION IS COMPLETED BY THE ANAESTHETIST AT TIME OF YOUR PROCEDURE

SEDATION / ANAESTHESIA PROPOSED ANAESTHESIA:

Local General Sedation Regional Block Other

RISK DISCUSSION:

.....
.....

RISKS DISCUSSED:

Sore Throat Nausea/Vomiting Dental/Oral Damage Allergic Reaction
 Itch LA Toxicity Block Failure Nerve Damage
 Headache Hypertension/Hypotension Rare Serious Events

Other

PAIN RELIEF PLAN:

Oral Intravenous PCA Epidural Spinal Wound Catheter Other

COMMENTS:

.....
.....

I have discussed the proposed anaesthesia plan and possible alternatives with the:

Patient Parent / Guardian Next-of-Kin Spouse / Partner

I have provided written information to the patient.

ANAESTHETISTS DETAILS:

SPECIALIST SIGN HERE SIGNATURE Name Date

THIS SECTION IS COMPLETED BY THE PATIENT (OR PARENT/GUARDIAN) WITH THE ANAESTHETIST

- I, [name of patient or parent/guardian], agree to anaesthesia/sedation being given to myself / my child (delete one), [name of patient].
- I have discussed the proposed anaesthesia plan. I am aware that this plan may change during the procedure / surgery if medically appropriate.
- I understand that anaesthesia and all anaesthetic procedures have risks.
- I have been given the opportunity to ask questions about these risks and I am satisfied with the answers to my questions.
- I understand I may seek more information at any time.

SIGN HERE SIGNATURE [By patient or parent / guardian if patient is under 16] Date

DETAILS OF GUARDIAN IF SIGNING ON BEHALF OF THE PATIENT:

Name Home Phone
Address Work Phone
..... Mobile Phone

If you are not the patient, please state your relationship to the patient:

If applicable please attach evidence of your enduring power of attorney for care and welfare.



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HOSPITAL REGISTRATION FORM

PATIENT DETAILS

TITLE Mr Mrs Ms Master Miss Other **GENDER** Male Female

Surname First Names

Preferred Name Date of Birth

Physical Address Postal Address

.....

.....

Home Phone Work Phone

Mobile Phone Email

Note this may be used for emailing you your hospital account

ETHNICITY European NZ Maori Pacific Island African Asian Latin American / Hispanic

Middle Eastern Other **NZ RESIDENT** Yes No

GENERAL PRACTITIONER

Practice Doctor

Address Phone

EMERGENCY CONTACT

This is the person we will contact in case of an emergency. Please make sure this person is aware you are having this operation.

Name Home Phone

Relationship

Address Work Phone

..... Mobile Phone

DISCHARGE CONTACT

This is the person we will contact after the operation and who will collect you from the Hospital. Please make sure this person is aware you are having this operation.

Same as emergency contact

Name Home Phone

Address Work Phone

..... Mobile Phone

PAYMENT OF YOUR HOSPITAL ACCOUNT

Please indicate below how the procedure will be paid for (tick one or more boxes):

HEALTH INSURANCE

Are you covered by Health Insurance? Yes No - Please see Personal Payment section on reverse of this form.

Name of Medical Insurance Company

Please obtain a prior approval letter or email from your insurance company. A copy must be provided to us prior to your admission.

Please email to reception@fortehealth.co.nz

If you have partial cover or an excess to pay - please see Personal Payment section below.

For insurance claims, please forward all invoices promptly to your insurance company to enable them to process the claim promptly.

Please note, the Hospital does not send invoices directly to insurance companies. Liability for payment of all invoices remains with the policy holder.

Tear here to remove from book.

PAYMENT OF YOUR HOSPITAL ACCOUNT *CONT.*

PERSONAL PAYMENT

If you are funding the surgery yourself, have partial cover or an excess to pay under your insurance policy you will be required to make this payment prior to your admission.

Please contact accounts on 03 365 8333 or email patientaccounts@fortehealth.co.nz to obtain an indication of the cost and arrange your payment.

Please note that the Hospital will give you an approximation based on known average costs. Approximations will be as accurate as possible but the actual cost of any operation can vary significantly from the approximation if your surgery is more, or less, complex than anticipated.

METHODS FOR PAYMENT OF YOUR ACCOUNT

Cheque, Cash, EFTPOS or Credit Card *[Visa & Mastercard accepted]*. Please pay at Forté Health reception.

Internet Banking, please make the payment to the following account:

Forté Health Limited; Account number: 12-3191-0032331-00 and use your invoice number and full name as a reference.

ACC

Are you covered by ACC? Yes No

Area Office Claim Number

Please note: Any costs not covered by ACC will be invoiced to you personally.

PATIENT AGREEMENT - ALL PATIENTS TO COMPLETE

- I agree to settle my Hospital account in full when personally paying my account or where I do not have "prior approval" from my funder. I understand I will be required to make a payment towards the estimated cost of my Hospital account prior to my admission to Hospital.
- I understand that I will be required to pay any part of my account that will not be covered by my funder prior to my admission to Hospital.
- I agree to settle the balance of my account in full within 7 days of invoice date if the account is being paid personally or prior approval has not been obtained from my funder.
- I accept that in the event the Hospital account is not paid, the account holder contact details will be forwarded to a debt collection agency. I also understand that debt collection costs will be added to the account.
- I authorise the Hospital to obtain from my insurance company or funder information regarding my claim(s), and I authorise my insurance company or funder to disclose such information to the Hospital.
- I understand that the Specialist/Surgeon, Anaesthetist, Radiology and Physiotherapy are independent of the Forté Hospital with respect to my treatment and care.
- I understand there may be three or more separate charges for my operation/procedure. These will be from the hospital, Specialist/Surgeon, your anaesthetist and any attendance based services e.g. radiology and physiotherapy.
- I have read and understood the terms and conditions for fees as outlined above and agree to abide by them.

SIGN
HERE

SIGNATURE *[By patient or parent / guardian if patient is under 18]* Date

DETAILS OF GUARDIAN IF SIGNING ON BEHALF OF THE PATIENT:

Name Home Phone

Address Work Phone

..... Mobile Phone

If you are not the patient, please state your relationship to the patient:

If applicable, please attach evidence of your enduring power of attorney.

Tear here to remove from book.



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PATIENT HEALTH QUESTIONNAIRE

THIS FORM IS PART OF YOUR CLINICAL RECORDS. PLEASE PRINT CLEARLY.

Surname First Names

Date of Birth NHI Date of Form Completion

All questions in this questionnaire are about the person being treated at the Hospital. If you are filling this out for your child, only provide information relating to your child's health.

LIST PROCEDURES / OPERATIONS / HOSPITAL ADMISSIONS THE PATIENT HAS HAD *[start with the most recent and work backwards]*

Procedures / Operations / Hospital Admissions	Year	Hospital
.....
.....
.....
.....

Please tick YES or No for all fields, circle a word where appropriate and add comments in the spaces provided.

DO YOU CURRENTLY HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? *[please complete the following fields]*

	YES	NO	DETAILS		YES	NO	DETAILS
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	CPAP Machine Required	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain / Angina	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn / Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heart Beat / Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots (Legs / Lungs)	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding / Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>
Blackouts or Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy / Bad Headaches / Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Stroke or (TIA) Minor Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis / Jaundice / Liver Problems	<input type="checkbox"/>	<input type="checkbox"/>
Asthma or Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>
In Hospital for Asthma	<input type="checkbox"/>	<input type="checkbox"/>	MRSA, ESBL, VRE, Novovirus	<input type="checkbox"/>	<input type="checkbox"/>
Stop Breathing in Sleep	<input type="checkbox"/>	<input type="checkbox"/>	TB or Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Climbing Stairs	<input type="checkbox"/>	<input type="checkbox"/>	Substance Dependency	<input type="checkbox"/>	<input type="checkbox"/>

ANY OTHER MAJOR ILLNESSES OR CONDITIONS? *[please specify: e.g Kidney problems, Thyroid Disease, Muscular Dystrophy or Liver problems]*

.....

	YES	NO	
RECREATIONAL DRUGS	<input type="checkbox"/>	<input type="checkbox"/>	If YES, how much?
DO YOU DRINK ALCOHOL DAILY?	<input type="checkbox"/>	<input type="checkbox"/>	If YES, how much?
DO YOU SMOKE / HAVE YOU SMOKED?	<input type="checkbox"/>	<input type="checkbox"/>	If YES, how much?

ARE THERE ANY MEDICAL CONDITIONS OR HEALTH PROBLEMS THAT RUN IN YOUR FAMILY? *[please specify]*

.....

HAVE YOU EVER HAD ANY ALLERGIC REACTIONS TO MEDICATIONS, LATEX, IODINE, PLASTERS, FOOD OR ANY OTHER SUBSTANCE? Yes No If YES, please specify allergies and describe the reactions:

.....

DO YOU TAKE MEDICATIONS OR REMEDIES FOR:

	YES	NO
Blood Thinning (e.g. Warfarin, Aspirin, Clopidogrel)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease or High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes or Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Sleeplessness	<input type="checkbox"/>	<input type="checkbox"/>
Emotional Disorders	<input type="checkbox"/>	<input type="checkbox"/>

DO YOU TAKE:

	YES	NO
Cortisone (Steroids) or Anti-inflammatories	<input type="checkbox"/>	<input type="checkbox"/>
Oral Contraception or HRT	<input type="checkbox"/>	<input type="checkbox"/>

THESE QUESTIONS ARE DESIGNED TO PROVIDE INFORMATION THAT WILL HELP US GIVE YOU THE BEST CLINICAL CARE

Please tick YES or No for all fields, circle a word where appropriate and add comments in the spaces provided.

	YES	NO	DETAILS
Have you or any other family member (blood relative) had any problems with an anaesthetic?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a 'head cold', throat/chest infection or bronchitis in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had diarrhoea and/or vomiting in the last 3 days?	<input type="checkbox"/>	<input type="checkbox"/>
Do you believe you are pregnant?, If YES, how many weeks?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been unwell/admitted to hospital in NZ or overseas in the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, please specify: where			and why

DO YOU WEAR:

<input type="checkbox"/> Dentures	<input type="checkbox"/> Partial Plate	<input type="checkbox"/> Capped Teeth
<input type="checkbox"/> Hearing Aid	<input type="checkbox"/> Contact Lenses	<input type="checkbox"/> Glasses
Other		

DO YOU HAVE:

<input type="checkbox"/> Joint Implants	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Heart Valve
<input type="checkbox"/> Implants	<input type="checkbox"/> Piercings	<input type="checkbox"/> Other Prosthesis
Other		

DO YOU SUFFER FROM MOTION SICKNESS:

<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Details		

PLEASE PROVIDE: (IMPORTANT FOR YOUR ANAESTHETIC)

Your Weight kg Your Heightcm
 BMI.....

DO YOU HAVE ANY SPECIAL NEEDS YOU WOULD LIKE US TO CONSIDER WHEN PLANNING YOUR CARE?

If YES, please provide more detail below.

	YES	NO	DETAILS
Disability	<input type="checkbox"/>	<input type="checkbox"/>
Physical Support or Aids	<input type="checkbox"/>	<input type="checkbox"/>
Religious or Spiritual Needs	<input type="checkbox"/>	<input type="checkbox"/>
Cultural or Family/Whanau Needs	<input type="checkbox"/>	<input type="checkbox"/>

DIETARY REQUIREMENTS Standard Diabetic Vegetarian Gluten Free Other

DO YOU HAVE ANYTHING WE NEED TO KNOW THAT YOU PREFER NOT TO STATE HERE? Yes No
 If YES, please discuss with the Nurse/Medical Specialist when you arrive at the Hospital.

DO YOU HAVE ANY ANXIETIES, CONCERNS, QUESTIONS OR ADDITIONAL MATTERS YOU WISH TO DISCUSS BEFORE SURGERY? Yes No
 If YES, please indicate with whom: Specialist Anaesthetist Nurse Administration

IF THE PROCEDURE REQUIRES REMOVAL OF BODY PARTS, DO YOU WISH THEM TO BE RETURNED FOR CULTURAL REASONS? Yes No
 Details

OTHER THAN UNDERGOING YOUR PROCEDURE/SURGERY, DO YOU HAVE ANY OTHER EXPECTATIONS OF YOUR VISIT TO THE HOSPITAL? Yes No
 e.g expectations of facilities, hospital visit, recovery time, visitor access, follow up.
 Details

FOR HOSPITAL USE ONLY

Comments

Responses checked prior to admission by (name and designation): Date

Responses checked on admission by (name and designation): Date

