

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 an 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.

Please make sure these completed forms are returned to us no later than five (5) business days before your admission. Post (this may take up to 5 working days), or deposit in our letterbox at the front entrance. If you have any questions please don't hesitate to get in touch.

YOUR ADMISSION INFORMATION

DATE OF ADMISSION

..... Arrive at AM PM

FASTING INSTRUCTIONS

Nothing to eat or drink from On

However water only until On

MEDICATION INSTRUCTIONS

Take All Usual Medications ☐ Yes ☐ No

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

*Please refer to the pink medication information sheet enclosed regarding approved medicines prior to surgery.

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 from your surgeon.

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

- ☐ You must not drive for 24hours after your anaesthetic /sedation.

- ☐ Please refer to pink **Medication Information** sheet.

- ☐ Please refer to **Your Anaesthetic** pamphlet enclosed.

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

- ☐ Arrange for someone responsible to look after you for the first 24hours after your anaesthetic/sedation.

- ☐ Bring your insurance company 'prior approval' letter.

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

- ☐ Bring 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.

- ☐ Bring any glasses, hearing or walking aids you require.

- ☐ Bring your medic alert bracelet (if you have one).

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 goal to provide the very best patient experience. We offer state-of-the-art surgical and patient facilities and an expert team who deliver quality, personalised care in our 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.

As well as providing care that is second to none, Forté Health is committed to environmental sustainability. Our building design includes numerous green features and is the first hospital building to have a green star rating, with Forté achieving four green star certification. Forté Health has also been awarded the Toitū Enviromark Gold Award for environmental sustainability, and we are proud to be the first hospital in New Zealand to achieve carbon zero certification status.

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. Our values reflect our commitment to your care.



PERFORMANCE



PERSON CENTRED



TEAMWORK



INNOVATIVE



INTEGRITY



SUSTAINABLE

OUR FOOD AND DIETARY SERVICE

Forté works in partnership with award-winning caterer White Tie to develop and deliver a quality catering service for our patients. All meals are ordered prior to admission.

Our set dinner menu changes seasonally, with patients able to choose from a range of continental breakfast options. Patients enjoy a light lunch and dinner service while in hospital, with meals also available for parents who stay overnight with their child.

White Tie shares Forté's sustainable ethos and sources products locally wherever possible, including fresh produce from Cultivate Christchurch, an urban farm just metres from Forté's doors.

Food allergies and specific requests may be able to be catered for, with prior notice. It may not always be possible to cater for complex dietary requirements. In this instance patients are welcome to bring their own food and snacks if necessary.



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 patientaccounts@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

Cash, EFTPOS or Credit Card *[Visa & Mastercard accepted, no surcharge applies]*. 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 surgery date 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 anaesthetic/sedation.

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 and accompany you home in a suitable vehicle at time of discharge. Please note, public transport is not suitable.

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, piercings and false tan.

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

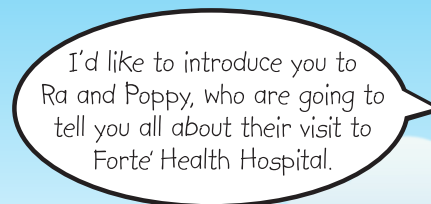
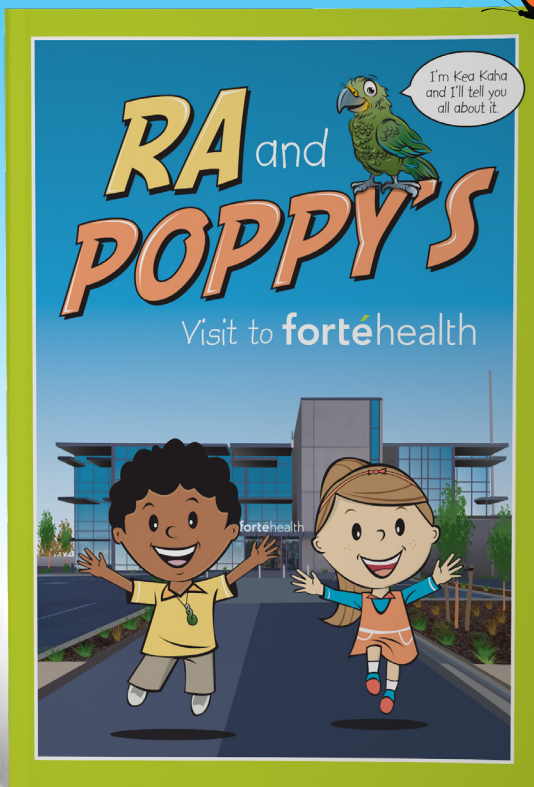
Parking: We provide limited on-site parking. The car park entrance is located on Peterborough Street.

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 family or a support person 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.



To reduce potential anxiety in children it is important to give them information at a level they can understand but without so much detail that it could cause concern. We recommend you share with your child **Ra and Poppy's Visit to Forté Health** - a book developed by Forté which prepares children for the hospital journey and helps them become familiar with our hospital environment.

SURGERY FOR CHILDREN

INFORMATION AND ADVICE

It is never easy when your child is undergoing a procedure. To help prepare children for hospital Forté has developed an award-winning paediatric programme, including the introduction of Ra Poppy and Kea Kaha - our special Forté friends developed to support our youngest patients through their hospital journey.

The experience and skill of our Forté staff will ensure your child has every possible care and attention. The information below may help guide you on how to best support your child before, during and after their procedure.

During: Hospital admissions can be a testing time for children and their parents or carers and there may be a wait time before their procedure. It is helpful to bring your child's favourite toys or books to keep them entertained. 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 the child's 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 stay at Forté Hospital. Please note, 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. We have a limited selection of nappies available, so we recommend you bring your own nappies, if required.

Forté's innovative approach to paediatric care is industry-leading, with Forté Health awarded the 2021 **Leaders in Quality Award** by the New Zealand Private Surgical Hospitals' Association for its paediatric initiatives.

For further information about Forté Hospitals paediatric initiatives, including a link to download the book '**Ra and Poppy's Visit to Forté Health**' go to www.fortehealth.co.nz If you have any other questions, please don't hesitate to ask us.



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 and go home once you have been assessed and ready for discharge. We can also call your contact person so they can pick you up when it is safe to do so. Please ensure you have a responsible adult to collect you and stay with you for 24 hours following your anaesthetic/sedation.

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.

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.



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 2020 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 us.

STAYING SMOKE-FREE

In the interests of both your health and that of others we have a smoke-free policy, this includes vaping. Please respect this and refrain from smoking or vaping 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 us.

ANY UNANSWERED QUESTIONS?

Further information is available on our website www.fortehealth.co.nz.

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

A low-angle photograph of a modern building facade. The building features large, light-colored rectangular panels and sections of teal-tinted glass. The sky is a clear, deep blue. In the foreground, the 'Forté Health' logo is mounted on a dark, angled surface. The logo consists of the word 'forté' in a white, lowercase, sans-serif font, followed by 'health' in a similar font. A small, bright yellow-green square is positioned above the 'e' in 'forté'.

forté health



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)
- 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 business 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 business 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.

EMAIL

Scan and email to reception@fortehealth.co.nz, **however you must 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 #

fortéhealth

Phone 03 365 8333
 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

Signature

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.

DETAILS OF GUARDIAN IF SIGNING ON BEHALF OF THE PATIENT:

IMPORTANT NOTES: (TICK IF APPLICABLE)

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

Continued over page >

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 in this request for treatment form 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 informed that a registrar may be involved in providing elements of the operation/procedure/treatment under the supervision of my admitting specialist. I have been told about the scope of the registrar's involvement and given an opportunity to ask questions. I consent to the presence and involvement of a registrar under the supervision of my admitting specialist.
- 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 the administration of anaesthesia/sedation to me/my child/my ward for the above procedure. I acknowledge that I/my child/my ward should not drive a motor vehicle, not operate machinery or potentially dangerous appliances, drink alcoholic beverages, or make important decisions for 24 hr after having a general anaesthetic and /or opioid or sedative agent has been administered, as mental alertness may be impaired
- 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 Forté 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 Forté Health, the admitting specialist, other health professionals, or other healthcare providers.
- I understand that Forté 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 Forté Health will be kept securely.
- I am aware that I can request more information and ask any questions about Forté Health's Privacy Policy and how information is collected, stored, used or disclosed by Forté Health at any time.
- I have read and understood the above information:

SIGN
HERE

PATIENT SIGNATURE **Date**

Details of Parent/Guardian if signing for patient under 16yrs or on behalf of patient

SIGN
HERE

SIGNATURE **Date**

Name(PRINT)

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

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

PLEASE NOTE:

It is important that before submitting each form that every question is answered in full; including the Yes / No tick boxes.

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

HOSPITAL REGISTRATION FORM

PATIENT DETAILS

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

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 - Iwi: ☐ 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 from your insurance company. A copy must be provided to us 5 days prior to your admission.

Please email to reception@fortehealth.co.nz

If you have an insurance excess or shortfall to pay, you will be required to make this payment prior to your admission.

For insurance claims post-surgery, please forward all invoices 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.

PLEASE NOTE:

It is important that before submitting each form that every question is answered in full; including the Yes / No tick boxes.

PAYMENT OF YOUR HOSPITAL ACCOUNT *CONT.*

SELF FUNDED

Are you funding the surgery yourself ☐ Yes ☐ No

Please contact accounts on 03 265 0728 or email patientaccounts@fortehealth.co.nz to obtain an indication of the cost and arrange your payment. You will be required to make this payment prior to your admission.

Please note that the Hospital will give you an approximation based on known average costs. Estimates will be as accurate as possible but can vary significantly due to individual circumstances.

METHODS FOR PAYMENT OF YOUR ACCOUNT

Cash, EFTPOS or Credit Card *[Visa & Mastercard accepted, no surcharge applies]*. 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 surgery date and full name as a reference.

ACC

Are you covered by ACC? ☐ Yes ☐ No

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.

PLEASE NOTE:

It is important that before submitting each form that every question is answered in full; including the Yes / No tick boxes.

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

PATIENT HEALTH QUESTIONNAIRE

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

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.

Surname First Names

Date of Birth NHI Date of Form Completion

Your Weight kg Your Height cm BMI

This information is important for your anaesthetic

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, Norovirus	<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?

If you would like information on smoking cessation, please contact us

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:

Continued over page >

**PLEASE COMPLETE YOUR FULL MEDICATION
LIST ON THE NEXT PAGE**

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 admitted into any overseas hospitals or travelled to South East Asia or Indian Subcontinent in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, please specify: where and why			

DO YOU WEAR:

☐ Dentures ☐ Partial Plate ☐ Capped Teeth
☐ Hearing Aid ☐ Contact Lenses ☐ Glasses
☐ None Other

DO YOU HAVE:

☐ Joint Implants ☐ Pacemaker ☐ Heart Valve
☐ Implants ☐ Piercings ☐ Other Prosthesis
☐ None Other

DO YOU SUFFER FROM MOTION SICKNESS:

☐ Mild ☐ Moderate ☐ Severe

Details

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

MEDICINE RECONCILIATION (MEDICATION LIST)

Surname First Names

Date of Birth NHI #

DO YOU TAKE ANY REGULAR MEDICATIONS? ☐ **Yes** ☐ **No** If **Yes** please complete table below



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

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 the 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 (see below)
3. You must bring a medicine card or print out from your GP or pharmacist with you to FHL hospital as well as completing the list below.
4. Please refer to pink medication information sheet regarding approved medications prior to surgery.

YOUR CURRENT MEDICINES

Patient to complete – list all medicines you currently use

[illegible]

HOSPITAL USE ONLY

TWO SOURCES OF VERIFICATION REQUIRED

Reconciled: Yes (Y) No (N); Not available (NA)

[illegible]

MEDICINE RECONCILIATION (MEDICATION LIST)

MEDICINE REMINDERS – WHICH OF THE EXAMPLES BELOW APPLY TO YOU?

There are many **types** of medicine

- Prescription medicines
- Vitamins
- Herbal medicines
- Supplements
- Natural medicines
- Contraceptives
- Homeopathic remedies
- Steroids
- Over-the-counter medicines

Medicines come in many **forms**

- Tablets
- Patches
- Capsules
- Creams
- Suppositories
- Inhalers
- Drops
- Syrups
- Injections

- Other liquids

Medicines are taken for many **common conditions**

- Heart disease
- Infections
- Diabetes
- High blood pressure
- Blood thinning
- Sleeplessness
- Dietary deficiencies
- Epilepsy
- Emotional conditions

ADMITTING NURSE TO COMPLETE

	YES	NO	
Medicines Verified by two sources	<input type="checkbox"/>	<input type="checkbox"/>	Sign and Date:.....
If 'NO' M.S has been alerted	<input type="checkbox"/>	<input type="checkbox"/>	Sign and Date:.....
STOP sign put in patients notes	<input type="checkbox"/>	<input type="checkbox"/>	Sign and Date:.....

DISCREPANCIES NOTED AND ACTIONS TAKEN:

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