

Surname
First Names
Date of Birth NHI #



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 >

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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**
- 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.

TICK ONE

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)

Tear here to remove from book.

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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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.

Tear here to remove from book.

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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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:

.....

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:

<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
<input type="checkbox"/> None	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
<input type="checkbox"/> 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)

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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