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.

Please ensure this form is returned to Forté Hospital at least five (5) business days before admission.

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

Tear here to remove from book.

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.

Please ensure this form is returned to Forté Hospital at least five (5) business days before admission.

Tear here to remove from book.

Surname ....

First Names ....

Date of Birth .... NHI # ....

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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

Continued over page >

Please ensure this form is returned to Forté Hospital at least five (5) business days before admission.

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 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 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 **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)

Tear here to remove from book.

Please ensure this form is returned to Forté Hospital at least five (5) business days before admission.

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

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.

Continued over page >

Please ensure this form is returned to Forté Hospital at least five (5) business days before admission.

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.*

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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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	☐	☐	....	CPAP Machine Required	☐	☐	....
Chest Pain / Angina	☐	☐	....	Diabetes	☐	☐	....
Heart Attack	☐	☐	....	Heartburn / Acid Reflux	☐	☐	....
Irregular Heart Beat / Palpitations	☐	☐	....	Blood Clots (Legs / Lungs)	☐	☐	....
High Blood Pressure	☐	☐	....	Bleeding / Easy Bruising	☐	☐	....
Blackouts or Fainting	☐	☐	....	Epilepsy / Bad Headaches / Seizures	☐	☐	....
Stroke or (TIA) Minor Stroke	☐	☐	....	Arthritis	☐	☐	....
Shortness of Breath	☐	☐	....	Hepatitis / Jaundice / Liver Problems	☐	☐	....
Asthma or Bronchitis	☐	☐	....	HIV / AIDS	☐	☐	....
In Hospital for Asthma	☐	☐	....	MRSA, ESBL, VRE, Norovirus	☐	☐	....
Stop Breathing in Sleep	☐	☐	....	TB or Rheumatic Fever	☐	☐	....
Difficulty Climbing Stairs	☐	☐	....	Substance Dependency	☐	☐	....

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

....

	YES	NO	
RECREATIONAL DRUGS	☐	☐	If YES, how much? ....
DO YOU DRINK ALCOHOL DAILY?	☐	☐	If YES, how much? ....
DO YOU SMOKE / HAVE YOU SMOKED?	☐	☐	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:

....

Continued over page >

Please ensure this form is returned to Forté Hospital at least five (5) business days before admission.

DO YOU TAKE MEDICATIONS OR REMEDIES FOR:

	YES	NO
Blood Thinning (e.g. Warfarin, Aspirin, Clopidogrel)	☐	☐
Heart Disease or High Blood Pressure	☐	☐
Diabetes or Epilepsy	☐	☐
Sleeplessness	☐	☐
Emotional Disorders/Anxiety	☐	☐

DO YOU TAKE:

	YES	NO
Cortisone (Steroids) or Anti-inflammatories	☐	☐
Oral Contraception or HRT	☐	☐

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?	☐	☐	....
Have you had a 'head cold', throat/chest infection or bronchitis in the past 4 weeks?	☐	☐	....
Have you had diarrhoea and/or vomiting in the last 3 days?	☐	☐	....
Do you believe you are pregnant? If YES, how many weeks?	☐	☐	....
Have you been admitted into any overseas hospitals or travelled to South East Asia or Indian Subcontinent in the past 12 months?	☐	☐	....

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	☐	☐	....
Physical Support or Aids	☐	☐	....
Religious or Spiritual Needs	☐	☐	....
Cultural or Family/Whanau Needs	☐	☐	....

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 ....

Tear here to remove from book.

MEDICINE RECONCILIATION (MEDICATION LIST)

fortéhealth

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

Surname .... First Names ....

Date of Birth .... NHI # ....

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

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.**

YOUR CURRENT MEDICINES

Patient to complete – list all medicines you currently use

NAME OF MEDICINE	STRENGTH	HOW MUCH YOU USE, AND WHEN
Example... Paracetamol	500mg	2 caps every 6 hrs

HOSPITAL USE ONLY

TWO SOURCES OF VERIFICATION REQUIRED

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

Medicine Container	Medication Card	Patient or Whanau/ family	Other (state) e.g. phoned GP/ Healthone	Comment if no	**ON ADMISSION:** Date/time last taken

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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	☐	☐	**Sign and Date:**..
If 'NO' M.S has been alerted	☐	☐	**Sign and Date:**..
STOP sign put in patients notes	☐	☐	**Sign and Date:**..

DISCREPANCIES NOTED AND ACTIONS TAKEN:

....

....

....

....

....

....

....

....

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