Admission Form

Manuka Street Trust Hospital

get well sooner

www.manukastreet.org.nz

IMPORTANT: *Please complete all sections and both sides of the form and post or fax* ***10 days prior to surgery or as soon as possible to:*** *Manuka Street Trust Hospital, 36 Manuka Street, Nelson, Fax to: (03) 548 2767 or email to: administration@manukastreet.org.nz*

Patient Label
(office use only)

Personal Details Admission Date ____ Previous Admission to MSTH (year) ____

Mr/Mrs/Mstr/Miss/Dr ____

SURNAME — GIVEN NAMES - LIST ALL

Preferred Name ____ Date of Birth ____ Age ____

KNOWN AS

Address ____

Telephone: Home ____ Work ____ Mobile ____

Email ____ Occupation ____

Surgeon ____ G.P. ____

Operation ____

Ethnicity: NZ European / Maori / Other (please state) ____

Next of Kin / Contacts

1) Name ____ Relationship ____

Address if different from the above ____

Telephone: Home ____ Work ____ Mobile ____

2) Name ____ Relationship ____

Address if different from the above ____

Telephone: Home ____ Work ____ Mobile ____

Treatment been approved by ACC Yes ☐ No ☐ ACC Claim number ____

Name of Medical Insurer ____ Pre-approval number ____

Do you have any special cultural/spiritual requirements? Yes ☐ No ☐

If yes, please detail ____

Do you have any special dietary requirements? No ☐ Request ____

Do you require an interpreter Yes ☐ No ☐ Language ____

Do you require an advocate Yes ☐ No ☐

Please complete both sides of this form.

Patient signature ____ Date ____

Health Information Privacy Explanation

Under the provisions of the Health Information Privacy Code 1994 there is a requirement to collect and store information about each patient to help provide good and safe treatment. It is mandatory to send certain health information to other organisations such as the Ministry of Health. Your medical records will be kept secure and will only be accessed by authorised personnel. You as a patient, have right of access to your notes for as long as Manuka Street Trust Hospital stores them. During this time, if you desire, you can update or correct your medical notes. Requests for access to your notes should be made through our Privacy Officer.

On the day of your operation until you are able to receive phone calls, our reception or nursing staff will provide callers with a general statement regarding your health, unless advised otherwise.

If you do not wish to have any information disclosed about your stay - please inform us on admission.

If for any reason you require to be transferred to another hospital a copy of your notes from Manuka Street Trust Hospital will accompany you. On discharge, and with your permission, a summary of your treatment will be sent to your General Practitioner by your surgeon.

A copy of the Health Information Privacy Code is available for further information if desired.

OFFICE USE ONLY ☐ Checked ☐ Referred to Dr. .....

OFFICE USE ONLY
Diet request form completed ☐

Health Questionnaire

Admission Form

Name _____ Signature _____

Do you regualarly take any medications? YES ☐ NO ☐

MEDICATIONS. YOU MUST OBTAIN A PRINTED LIST OF ALL YOUR CURRENT MEDICATIONS FROM YOUR GP OR PHARMACIST AND BRING IT WITH YOU FOR ADMISSION (A HAND WRITTEN LIST IS NOT ACCEPTABLE). THIS IS REQUIRED BY LAW. ***IMPORTANT - If you do not provide this information your surgery may be delayed or cancelled.***

- *Non prescription medications you regularly take e.g. homeopathic, vitamins etc. will be discussed with you on admission.*
- *Bring all medications with you on admission in* ***their original containers with contents clearly identified****.*
- *Continue taking all prescription medications prior to admission unless advised otherwise.*

Have you ever had a problem with anaesthetic: If yes please detail	YES ☐	NO ☐
Has any member of your family had a problem with anaesthetic: If yes please detail	YES ☐	NO ☐
Have you ever had any major illnesses, injury, previous anaesthetics or hospital admissions? Please detail	YES ☐	NO ☐
When was your last anaesthetic? Please detail		
Are you allergic to anything? If yes, list and describe reaction (e.g. sensitivity to latex, rash/swelling etc)	YES ☐	NO ☐

Have you ever had problems with the following:	**YES**	**NO**	**COMMENTS**
Heart disease, e.g. chest pain, rheumatic fever, heart attack, angina, aneurysms	☐	☐	.....
Cardiac Bypass, Aortic surgery	☐	☐	.....
High blood pressure	☐	☐	.....
Lung disease e.g. Asthma, breathing problems	☐	☐	.....
Liver disease e.g. jaundice, hepatitis	☐	☐	.....
Kidney disease / urinary problems	☐	☐	.....
Abnormal bruising or bleeding	☐	☐	.....
Anaemia, other blood disorders or family history of blood disorders	☐	☐	.....
Blood clots (legs or lungs)	☐	☐	.....
Diabetes	☐	☐	.....
Epileptic fits	☐	☐	.....
Migraines or severe headaches	☐	☐	.....
Substance dependency e.g. morphine	☐	☐	.....
HIV or Hepatitis C	☐	☐	.....
Stroke, CVA, TIA (Transient Ischaemic Attack)	☐	☐	.....
Dementia	☐	☐	.....
Problems with neck or opening your mouth	☐	☐	.....
Spinal problems (e.g. surgery)	☐	☐	.....
Sleep problems e.g. Apnoea	☐	☐	.....

General questions:	**YES**	**NO**	**COMMENTS**
If your procedure requires the removal of any body parts, would you like them returned?	☐	☐	.....
Could you be pregnant?	☐	☐	.....
Do you smoke? If yes, how many per day?	☐	☐	.....
Do you drink alcohol? If yes, average intake per week	☐	☐	.....
Do you have dentures, plates or crowns etc?	☐	☐	.....
Have you ever been told that you were carrying or infected with MRSA in the past? Refer to MRSA information leaflet.	☐	☐	.....
Have you had close contact (e.g., family member, partner, flatmate) with someone with MRSA in the last 2 years?	☐	☐	.....
Have you been a patient in, or been a support person of a patient (providing physical care) in another hospital or rest home outside of the Nelson Marlborough region or overseas in the last 6 months?	☐	☐	.....
Have you worked at another hospital, rest home or other health care agency outside of the Nelson Marlborough region or overseas in the last 6 months?	☐	☐	.....

Please complete both sides of this form.