



We need you to complete three pre-admission forms

We appreciate it can be a chore to complete forms, but to provide safe and personalised care we need current information from you.

We need to receive your completed forms before your admission



To enable us to properly prepare for your admission, we need to receive all three completed forms at least one week prior to your admission.

You can hand deliver, scan and email, or post the forms*.

If you post the forms, please allow 1-2 weeks extra for delivery.

* The physical address and email address of Franklin Hospital are listed on the hospital information sheet in Your Admission Pack. A FreePost envelope is also included in the pack.

1

First we need you to agree to receive treatment at our hospital.

Agreement to treatment

Completed and signed by you and your admitting doctor.

2

Next we need your personal and payment or insurance details.

Patient admission form

Completed and signed by you.

3

We also need to know your current state of health and your medical and surgical history, and we need an up-to-date list of the medicines you are currently taking. This information, along with your personal needs and preferences, will allow us to tailor your care throughout your hospital stay.

Patient health questionnaire

Completed by you.

We protect your privacy

Any information and personal data gathered for the purpose of your visit to Franklin Hospital is to assist in your treatment, for quality assurance activities, and to fulfill legislative requirements. Your rights provided in the Health Information Code and Privacy Act 1993¹ will be respected, including your right to access and correct any information held about you. If you have any concerns, please contact the hospital manager².

1. More information can be found in the patient Information Compendium located in your hospital room or day-stay area, as well as online at www.privacy.org.nz
2. The hospital manager is the hospital's Chief Executive Officer.

1. Agree to treatment

IMPORTANT: Please return this completed form to Franklin Hospital.

THIS SECTION IS COMPLETED BY THE ADMITTING DOCTOR

Surname (family name): _____

First name (s): _____

Patient's date of birth: ____ / ____ / ____ Diagnosis: _____

Procedure/operation/treatment description: _____

Operative side of body: Left / Right / Bilateral / Not applicable *(please circle)*

Sedation: Yes No Anaesthesia: Yes No Proposed anaesthesia: general / local / regional / spinal / epidural
(please circle)

Admission details

Admission date: ____ / ____ / ____ Admission time: _____ Procedure/Surgery date: ____ / ____ / ____
(If different to admission date)

Day stay unit Day inpatient Overnight inpatient Anticipated length of stay _____ hours / days / nights

Admitting doctor's instructions: _____

Admitting doctor's name: _____ Surgeon / Physician / General Practitioner
(please circle)

Admitting doctor's signature: _____ Date: ____ / ____ / ____
(Where applicable please attach evidence of enduring power of attorney)

THIS SECTION IS COMPLETED BY THE PATIENT/GUARDIAN/ENDURING POWER OF ATTORNEY

I, _____ agree to have the procedure/operation/treatment described
(Patient's/Guardian's full name)

above performed on myself / my child _____ at Franklin Hospital.
(Please circle) *(Name of patient, if patient not signing form)*

I confirm that I have received a satisfactory explanation of the reasons for, risks and likely outcomes of the procedure/operation/treatment, and the possibility and nature of further related treatment including a return to theatre, should any complications arise.

I have had an opportunity to ask questions and understand that I may seek more information at any time and participate in decision making about my treatment.

I have been provided with sufficient information by my doctor in relation to the administration of blood components / blood products if necessary.

I give consent to the administration of blood or blood products if necessary: Yes No

I understand that should a member of the healthcare team be directly exposed to my blood or other body fluids, I agree to blood samples being taken and tested. These samples will be tested only to identify such transmissible diseases as are considered of significant risk (e.g. Hepatitis and HIV). I understand I will be informed of the results if I request them, and any need for further medical referral. The results of these tests are confidential to me, the health professional(s) and the team member involved.

I give permission to Franklin Hospital or any health professional (such as my medical specialist) involved in my care in relation to this admission to Hospital, to access health information about me that is relevant to my treatment (including pre-admission and after discharge), which may be held by Franklin Hospital, other health professionals or other health organisations.

Patient/Guardian signature: _____ Date: ____ / ____ / ____

If not patient, state relationship to patient: _____
(Where applicable please attach evidence of enduring power of attorney)

Please turn over

ANAESTHESIA PLAN AND CONSENT

THIS SECTION IS COMPLETED BY THE ANAESTHETIST

Sedation: Yes No Anaesthesia: Yes No Proposed anaesthesia: general / local / regional / spinal / epidural
(please circle)

Other: _____

Risk discussion

Sore Throat Nausea/Vomiting Dental Damage Allergic Reaction Itch Blood Clots
Block Failure Nerve Damage Headache Hypotension Rare Serious Events Pain Bleeding

Other: _____

Pain Relief Plan

Oral Intravenous PCA Epidural Spinal Wound Catheter Other

Discussion notes: _____

Anaesthetist Statement

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

Patient Parent/Guardian Spouse/Partner Next-of-kin EPOA

Anaesthetist Signature: _____ Date: ____d / ____m / ____y

Anaesthetist Name: _____

THIS SECTION IS COMPLETED BY THE PATIENT/GUARDIAN/ENDURING POWER OF ATTORNEY

I, _____ agree to anaesthesia/sedation being given to
(Patient's/Guardian's full name)

myself / my child _____
(Please circle) *(Name of patient, if patient not signing form)*

I confirm that I have received a satisfactory explanation of the reasons for, risks and likely outcomes of the anaesthesia and

I have had the opportunity to ask questions and understand I may seek more information at any time.

I understand the proposed anaesthesia may change as deemed necessary by the Anaesthetist.

I acknowledge that I should not drive a motor vehicle, operate machinery or potentially dangerous appliances, or make important decisions for 24 hours after having had the anaesthesia.

Patient/Guardian signature: _____ Date: ____d / ____m / ____y

If not patient, state relationship to patient: _____

(Where applicable please attach evidence of enduring power of attorney)

2. Patient admission form

IMPORTANT: Please return this completed form to Franklin Hospital.

PERSONAL AND ADMINISTRATION DETAILS

Surname (family name): _____ Mr Mrs Ms Miss Mstr Dr

First name (s): _____ Preferred name: _____

Date of birth: ____/____/____ Gender: Male Female NHI: _____

Residential address: _____

Postal address: _____

Email address: _____

Telephone: (Home) _____ (Business) _____ (Mobile) _____

New Zealand resident: Yes No

Ethnicity: European / Māori / Pacific Island / Asian / Middle Eastern / Latin American / African / Other _____
(Please circle one or more)

General Practitioner (Name): _____ Telephone: _____

Medical Centre: _____

NEXT OF KIN/CONTACT PERSON

Name: _____ Relationship to patient: _____

Address: _____

Telephone (Home) _____ (Business) _____ (Mobile) _____

PAYMENT DETAILS

How will your procedure be paid for? Tick and complete as many as applies:

Health insurance (personal expenses such as telephone calls are excluded)

Name of Insurer: _____

Insurance Plan Name: _____ Membership No: _____

Have you obtained 'prior approval' for payment: Yes No Approval No: _____
(Provide your prior approval letter)

ACC (personal expenses such as telephone calls are excluded) **DHB** (personal expenses such as telephone calls are excluded)

Paid personally If you are paying for the procedure yourself, you may be asked to pay an estimated deposit 3-5 days before admission. The balance of your account must be settled on discharge.

I will pay my account by: EFTPOS Credit card Debit card Internet Banking

For Internet Banking:

Payee: Franklin Private Hospital Limited Bank a/c: 02-1256-0158770-000

Particulars: Patient Name Code: Date of Surgery e.g. 12 Sep 2021 Reference: Invoice number

AGREEMENT

I agree to settle my hospital account in full at the time of my discharge when personally paying my account or where I do not have 'prior approval' from my insurer. I understand I am responsible for any outstanding balance if my procedure is not fully covered by insurance, ACC or other contract.

I give permission for Franklin Hospital to obtain any information relating to the approval/claim for this admission from the relevant funder(s), and I authorise that person or organisation to disclose such information to Franklin Hospital. I accept that, in the event my hospital account is not met, Franklin Hospital reserves the right to add all costs of collection to this account.

I give permission to Franklin Hospital or any health professional involved in my care for this admission to hospital, to access health information about me that is relevant to my current treatment, which may be held by Franklin Hospital, other health professionals or other health organisations. I understand that other clinical team members such as student nurses and qualified medical trainees may have supervised involvement with my care and that I have the right to decline their presence or contribution to my care delivery.

I understand the admitting Surgeon, Anaesthetist and other Doctors or health professionals using Franklin Hospital facilities are independent and not employees of Franklin Hospital, with respect to both my treatment, care and account payment. I accept that this agreement is covered by New Zealand law. The details above have been completed by:

Name: _____ Date: ____/____/____

Signature: _____ If not patient, state relationship to patient: _____

3. Patient health questionnaire

IMPORTANT: Please return this completed form to Franklin Hospital.

The hospital needs to receive all three forms at least one week prior to your admission. You can hand deliver, scan and email, or post the forms. If you post the forms, please allow 1-2 extra weeks for delivery.

Please complete this questionnaire carefully as the information you supply helps us to provide you with the best and safest possible care during your stay at our hospital. The questionnaire has four sections:

- A** Your general health
- B** In preparation for your hospital admission
- C** In preparation for your procedure
- D** Your current medicines

Surname (<i>family name</i>) _____		
First name (s) _____		Hospital Administration only (Patient label)
Height _____ metres	Weight _____ kilograms	Surgeon _____ NHI (if known) _____ Occupation (optional) _____

All questions in this questionnaire are about the person being treated at the hospital (the patient). If you are filling this out for the patient, only provide information relating to the patient's health.

SECTION A: YOUR GENERAL HEALTH

A1. MEDICAL PROCEDURE HEALTH ALERTS

Do any of the following apply to you?				
Q	Yes	No		If Yes
1	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty climbing more than a flight of stairs	What restricts this activity?
2	<input type="checkbox"/>	<input type="checkbox"/>	Motion sickness	mild / moderate / severe (<i>circle one</i>)
3	<input type="checkbox"/>	<input type="checkbox"/>	Jaw problems (difficulty opening mouth)	Specify:
4	<input type="checkbox"/>	<input type="checkbox"/>	Problems with a previous anaesthetic	Specify:
5	<input type="checkbox"/>	<input type="checkbox"/>	Family history of problems with an anaesthetic	Specify:
6	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker or heart valve replacement	Specify:
7	<input type="checkbox"/>	<input type="checkbox"/>	Joint implants	Specify:
8	<input type="checkbox"/>	<input type="checkbox"/>	Other implants or prostheses	Specify:
9	<input type="checkbox"/>	<input type="checkbox"/>	Substance use or dependency	Specify:
10	<input type="checkbox"/>	<input type="checkbox"/>	Former smoker	When did you quit?
11	<input type="checkbox"/>	<input type="checkbox"/>	Currently on smoking cessation treatment	Specify:
12	<input type="checkbox"/>	<input type="checkbox"/>	Current smoker	How many per day?
13	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant or possibly pregnant	Approximate due date:
14	<input type="checkbox"/>	<input type="checkbox"/>	Medic Alert bracelet or necklace wearer	Specify:

SECTION A: YOUR GENERAL HEALTH (continued)

A2: YOUR MEDICAL CONDITIONS

Do you currently have, or have you previously had, any of the following conditions?
If Yes, please circle any applicable options and provide comments in the box below.

Q	Yes	No	
15	<input type="checkbox"/>	<input type="checkbox"/>	Breathing conditions: asthma wheeziness shortness of breath bronchitis croup emphysema COPD
16	<input type="checkbox"/>	<input type="checkbox"/>	Sleeping conditions: sleeplessness severe snoring obstructive sleep apnoea CPAP used
17	<input type="checkbox"/>	<input type="checkbox"/>	Heart conditions: palpitations irregular heart beat heart murmur angina heart attack chest pain congestive heart failure rheumatic fever
18	<input type="checkbox"/>	<input type="checkbox"/>	Stroke or Transient Ischaemic Attack (TIA)
19	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure or blood pressure controlled with medication
20	<input type="checkbox"/>	<input type="checkbox"/>	Blood clots: deep vein thrombosis (DVT) pulmonary embolus (PE)
21	<input type="checkbox"/>	<input type="checkbox"/>	Family history of blood clots
22	<input type="checkbox"/>	<input type="checkbox"/>	Blood or bleeding conditions: anaemia bruising
23	<input type="checkbox"/>	<input type="checkbox"/>	Family history of blood or bleeding conditions
24	<input type="checkbox"/>	<input type="checkbox"/>	Stomach and digestive conditions: indigestion heartburn acid reflux hiatus hernia peptic ulcer
25	<input type="checkbox"/>	<input type="checkbox"/>	Bowel conditions: irritable bowel syndrome constipation bowel disease
26	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease: jaundice hepatitis
27	<input type="checkbox"/>	<input type="checkbox"/>	Kidney conditions
28	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes: requiring insulin requiring tablets diet controlled
29	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid conditions
30	<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's disease
31	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy, seizures, blackouts or fainting
32	<input type="checkbox"/>	<input type="checkbox"/>	Migraines or severe headaches
33	<input type="checkbox"/>	<input type="checkbox"/>	Alzheimers or dementia
34	<input type="checkbox"/>	<input type="checkbox"/>	Mental function conditions: head injury concussion confusion or disorientation
35	<input type="checkbox"/>	<input type="checkbox"/>	Mental health conditions
36	<input type="checkbox"/>	<input type="checkbox"/>	Emotional conditions: anxiety phobia post traumatic stress disorder (PTSD)
37	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
38	<input type="checkbox"/>	<input type="checkbox"/>	Neck or back conditions
39	<input type="checkbox"/>	<input type="checkbox"/>	Gum or dental health conditions
40	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis (TB)
41	<input type="checkbox"/>	<input type="checkbox"/>	HIV or AIDS
42	<input type="checkbox"/>	<input type="checkbox"/>	Infection or treatment for resistant organisms: MRSA ESBL VRE OTHER
43	<input type="checkbox"/>	<input type="checkbox"/>	Cancer: If Yes, please specify and provide details of any recent treatment in the Comments box below
44	<input type="checkbox"/>	<input type="checkbox"/>	Other condition(s) not listed above: If Yes, please specify in the Comments box below

RE QUESTION YOUR COMMENT

19	GP says my blood pressure is slightly high, but I am not taking any medicine. --- Example ---

Need more space for your comments? Please continue on a separate sheet and attach it to this page.

Surname (family name)

First name (s)

Hospital Administration only
(Patient label)

SECTION B: IN PREPARATION FOR YOUR HOSPITAL ADMISSION

B1. YOUR ALLERGIES, SENSITIVITIES, OR INTOLERANCES

Q	Yes	No																
45	<input type="checkbox"/>	<input type="checkbox"/>	Are you allergic to latex?															
46	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any other allergies, sensitivities or intolerances? If Yes, please specify and describe the reaction using the box below															
		<table border="1"> <thead> <tr> <th></th> <th>Item</th> <th>Reaction</th> </tr> </thead> <tbody> <tr> <td>Skin related</td> <td>Plasters - - - Example - - -</td> <td>Rash - - - Example - - -</td> </tr> <tr> <td>Medicine related</td> <td></td> <td></td> </tr> <tr> <td>Food related</td> <td></td> <td></td> </tr> <tr> <td>Other</td> <td></td> <td></td> </tr> </tbody> </table>			Item	Reaction	Skin related	Plasters - - - Example - - -	Rash - - - Example - - -	Medicine related			Food related			Other		
	Item	Reaction																
Skin related	Plasters - - - Example - - -	Rash - - - Example - - -																
Medicine related																		
Food related																		
Other																		

B2. YOUR NEEDS AND PREFERENCES

Please answer these questions to help us to tailor how we care for you.
If you answer Yes to any of these questions, we may contact you to discuss your specific needs.

Q	Yes	No	If Yes
47	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a disability ? <i>Specify</i>
48	<input type="checkbox"/>	<input type="checkbox"/>	Do you have difficulty understanding English ? <i>Your preferred language:</i>
49	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any religious or spiritual needs you would like us to know about? <i>Specify:</i>
50	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any cultural or family needs you would like us to know about? <i>Specify:</i>
51	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any other special needs you would like us to know about? <i>Specify:</i>
52	<input type="checkbox"/>	<input type="checkbox"/>	If your procedure requires the removal of body parts , would you like them returned to you if this is possible?
53	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any dietary requirements ? <input type="checkbox"/> vegetarian <input type="checkbox"/> vegan <input type="checkbox"/> diabetic <input type="checkbox"/> gluten free <input type="checkbox"/> halal <input type="checkbox"/> dairy free <input type="checkbox"/> other _____
54	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any specific food dislikes ? <i>Specify:</i> <i>For allergies or intolerances, refer to question 46</i>

SECTION C: IN PREPARATION FOR YOUR PROCEDURE

C1. MEDICAL PROCEDURE HISTORY

Q	Yes	No																
55	<input type="checkbox"/>	<input type="checkbox"/>	Have you previously had any procedures/operations or other hospital admissions? - If Yes, please outline your previous admissions in the table below. If you need more space, please continue on a separate sheet and attach it to this page															
			<table border="1"> <thead> <tr> <th>Procedure or event</th> <th>Year</th> <th>Hospital</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>	Procedure or event	Year	Hospital												
Procedure or event	Year	Hospital																

C2. ANAESTHESIA CONSIDERATIONS

Q	Yes	No	
56	<input type="checkbox"/>	<input type="checkbox"/>	Have you had an anaesthetic before? <input type="checkbox"/> general <input type="checkbox"/> spinal <input type="checkbox"/> epidural <input type="checkbox"/> unsure
57	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any of these dental features? <input type="checkbox"/> upper denture <input type="checkbox"/> lower denture <input type="checkbox"/> crown(s) / cap(s) <input type="checkbox"/> partial plate <input type="checkbox"/> loose or chipped teeth
58	<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcohol? How much? _____

C3. PERSONAL ITEMS

Do you use any of these personal items?			
Q	Yes	No	<i>If Yes, use this space to provide details, if needed</i>
59	<input type="checkbox"/>	<input type="checkbox"/>	Mobility aids, such as a walking stick or cane
60	<input type="checkbox"/>	<input type="checkbox"/>	Glasses or contact lenses
61	<input type="checkbox"/>	<input type="checkbox"/>	Hearing aids
62	<input type="checkbox"/>	<input type="checkbox"/>	Earrings or other piercing jewellery

C4. BLOOD CLOT AND INFECTION CONSIDERATIONS

Q	Yes	No	
63	<input type="checkbox"/>	<input type="checkbox"/>	Have you recently been on a long distance flight?
64	<input type="checkbox"/>	<input type="checkbox"/>	In the past 3 days, have you had, or been in contact with anyone who has had, vomiting or diarrhoea?
65	<input type="checkbox"/>	<input type="checkbox"/>	In the past 7 days, have you experienced flu-like symptoms, or been in contact with anyone diagnosed with influenza?
66	<input type="checkbox"/>	<input type="checkbox"/>	In the past 4 weeks, have you had a head cold, throat or chest infection, or bronchitis?
67	<input type="checkbox"/>	<input type="checkbox"/>	In the past 12 months, have you travelled overseas, or been a patient or employee in a hospital or rest home in New Zealand or overseas? <i>If Yes, please specify</i> _____
68	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any boils, cuts, sores, scratches or other skin or urine infections?

C5. OTHER CONCERNS

Q	Yes	No	
69	<input type="checkbox"/>	<input type="checkbox"/>	Is there anything we need to know that you prefer not to write on this questionnaire? <i>If Yes, please discuss with your nurse or medical specialist when you arrive at the hospital</i>
70	<input type="checkbox"/>	<input type="checkbox"/>	Do you have anxieties, concerns, or questions you wish to discuss before your procedure? <i>If Yes, who would you like to speak with?</i> <input type="checkbox"/> your surgeon <input type="checkbox"/> your anaesthetist <input type="checkbox"/> a nurse <input type="checkbox"/> one of our admin staff

Surname (family name)

First name (s)

Hospital Administration only
(Patient label)

SECTION D: 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

- List below all medicines you currently use, and bring them with you to the hospital in their original containers
- To ensure you are clear what to include, please use the **MEDICINE REMINDERS** table (right →)
- If you have a medication card or printout from your GP or pharmacist, please bring it with you to the hospital, as well as completing the list below.

MEDICINE REMINDERS Which of the examples below apply to you?		
There are many types of medicine	Medicines come in many forms	Medicines are taken for many common conditions
prescription medicines	tablets	heart disease
herbal medicines	capsules	high blood pressure
natural medicines	inhalers	blood thinning
homeopathic remedies	drops	dietary deficiencies
over-the-counter medicines	syrops	emotional conditions
vitamins	patches	infections
supplements	suppositories	diabetes
contraceptives	creams	sleeplessness
steroids	injections	epilepsy

D1. YOUR CURRENT MEDICINES

Patient to complete - list ALL medicines you currently use.

Name of medicine Paracetamol --- Example ---	Strength 500mg	How much you use, and when 2 capsules every 6 hours	Reconciled: Yes (Y) No (N) Not available (NA)				Comment if No	ON ADMISSION: Date/time last taken
			Medicine container	Medication card	Patient or whānau/family	Other (state) eg. 'phoned GP'		

If required, please continue on the reverse

This is not a prescription or an instruction to administer medicines

