

**Patient to complete all sections and return to the hospital  
PRIOR TO ADMISSION to confirm your booking**

Boulcott Hospital Admissions  
PO Box 31459  
Lower Hutt 5040  
Phone: 569-7555 • Fax: 567-0041



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Surname ..... Given Names ..... Mr/Mrs/Ms/Miss/Master  
Preferred Name ..... Date of Birth..... Age..... Sex: M/F Ethnicity.....  
Address..... Postcode.....  
Telephone (H) ..... (Bus)..... (Mobile).....  
Family Doctor ..... NHI No (if known).....

Emergency Contact Name..... Relationship.....  
Address.....  
Telephone (Day) ..... (A/h).....

Special Dietary Requirements (please state).....  
.....  
Any other special needs – physical/cultural/spiritual/communication (please state).....  
.....  
.....

**Procedure:** .....

**Surgeon:** ..... Admission Date: .....

**Have your hospital treatment costs been approved by:**

**ACC:** YES / NO If so, ACC No: .....  
**Medical Insurance:** Policy No: ..... Approval No: .....  
Name of Company:.....

**Payment will be made by:** (please tick) Credit Card  Cheque  Cash  EftPos

**All costs are an APPROXIMATION only**

**HOSPITAL ADMINISTRATION ONLY**

Consent form checked..... Y   N  
Anaesthetist advised ..... Y   N  
Hospital advised ..... Y   N  
Hospital Notes/X-ray files available..... Y   N/A

Admission Clerk ..... Principal Nurse .....  
(Signature) (Signature)

**It is important that you answer all questions as accurately as possible. All information is sought to minimise your risk and will be retained as part of your confidential clinical records**

• **Do you suffer from, or have you ever suffered from, the following?** (circle Y for yes, N for no)

- |   |       |  |       |
|---|-------|--|-------|
| Chest pains/tightness or Angina .....     | Y / N | Shortness of breath .....                          | Y / N |
| Previous Rheumatic Fever .....            | Y / N | Asthma.....  | Y / N |
| Previous Heart Attack .....               | Y / N | Emphysema or Bronchitis.....                       | Y / N |
| Palpitations.....                         | Y / N | Tuberculosis.....                                  | Y / N |
| Heart Murmur .....                        | Y / N | Obstructive Sleep Apnoea.....                      | Y / N |
| High Blood Pressure.....                  | Y / N | Persistent Cough.....                              | Y / N |
| Artificial Heart Valve or Pacemaker ..... | Y / N | Kidney Disease.....                                | Y / N |
| Hiatus Hernia/Heartburn/Indigestion ..... | Y / N | Thyroid Disease.....                               | Y / N |
| Rheumatoid Arthritis .....                | Y / N | Prostate Conditions .....                          | Y / N |
| HIV/Aids .....                            | Y / N | Previous DVT or Lung Embolus.....                  | Y / N |
| Jaundice or Hepatitis .....               | Y / N | Stroke or Seizures .....                           | Y / N |
| Please specify type (if known).....       |       | Paralysis/Impaired sensation.....                  | Y / N |
|   |       | Pressure areas/skin ulcers .....                   | Y / N |
|   |       | Thin/fragile skin that bruises/breaks easily ..... | Y / N |
|   |       | Do you have wounds/broken skin at present .....    | Y / N |

Diabetes .....	Y / N
Insulin <input type="checkbox"/>	Oral Medication <input type="checkbox"/>
	Diet Controlled <input type="checkbox"/>

• **If you have answered yes to any of the above, please give further details below**

.....

.....

.....

• **Do you suffer from any other conditions, not covered elsewhere, that you feel we should know about?** If so, please outline Y / N

.....

• **Do you have any concerns or questions about your anaesthetic?** If so, please outline Y / N

.....

• **Have you been in any other hospital/resthome as a patient or staff member in the last 6 months?** Y / N

• **Have you ever been told you have MRSA, or other antibiotic resistant organism?** If so, please outline Y / N

.....

**Do you:**

<b>Your Weight:</b> .....	kg
<b>Your Height:</b> .....	metres

<b>Smoke:</b> .....	Y / N	How many? .....
<b>Drink Alcohol:</b> .....	Y / N	How much? .....
		How often? .....

• **Have you ever had a reaction/allergy to any medications, tablets, plasters, food, latex/rubber or any other substances?** If so, please list Y / N

Substance	Type of reaction	Substance	Type of reaction
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

Patient ID
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• Please list previous hospital admission including year and hospital (if known)

Reason for admission	Date	Hospital
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....

• Please bring with you all medications/remedies/supplements in their original containers to the hospital and a current printout from your GP or pharmacy that includes dosage regime. If your medications are in a blister pack please bring the entire pack

Medication	Dose	Time Taken	Medication	Dose	Time Taken
.....	.....	.....	.....	.....	.....
.....	.....	.....	.....	.....	.....
.....	.....	.....	.....	.....	.....
.....	.....	.....	.....	.....	.....
.....	.....	.....	.....	.....	.....
.....	.....	.....	.....	.....	.....
.....	.....	.....	.....	.....	.....
.....	.....	.....	.....	.....	.....
.....	.....	.....	.....	.....	.....

- Do you have problems opening your mouth? Y / N
- Have you been told of previous problems with your airway under anaesthesia? Y / N
- Do you have any of the following: (please tick those that apply)
  - dentures     partial plate     capped or loose teeth
- What physical activity(ies) do you take part in on a regular basis? (please tick those that apply)
  - walking     gym work     tennis     golf     others (list) \_\_\_\_\_
- I can climb  one     two     or more flights of stairs without getting short of breath
- My activity is restricted by: (please tick those that apply)
  - shortness of breath     chest pain     joint pain
- Women only – Are you, or could you, be pregnant? Y / N
- Are there any major illnesses, to your knowledge, within your blood relatives eg; diabetes, muscular dystrophy, malignant hyperthermia etc? If so, please outline Y / N
  - .....
  - .....
  - .....
- Have you or any of your family had problems with anaesthetic? If so, please outline Y / N
  - .....
  - .....
  - .....

The details above have been completed by: [PLEASE SIGN BELOW]

patient     guardian     relative     or other? (please tick)

Signed: ..... Date: .....

Patient ID

**Photographic Images:**

I understand that photographic images may be taken before/during and/or after my treatment as part of my clinical management

Agree  Disagree

**Teaching / Technical Support:**

**Medical / health related non medical personnel to be present during procedure**

I understand that for teaching / technical support this may require the attendance of a medical or health related non medical person.

Agree  Disagree  Wish to discuss further

Student nurses under the supervision of a Registered Nurse may be involved in my care

Agree  Disagree

Signed:..... Date.....

**Health Information:**

**We need to collect and store some information about you:** to comply with legislated requirements, to provide Government bodies with information to which they are legally entitled, and to help us provide safe treatment.

**We undertake:** only to collect information which is necessary for your treatment; only to use the information for its intended purposes; to keep the information securely in your medical file or in our computer system; only to allow authorised staff to use that information; only to pass on to Government bodies that information to which they are legally entitled; to allow you to check the accuracy of any information about you and request an addition to that information as you feel appropriate.

Do we have your permission to communicate with your family doctor? Yes  No

Do we have your permission to share information with your family relating to this admission? Yes  No

If yes, information may be shared with .....  
.....

I have read the above explanation and assurances and agree to the collection and storage of information.

Signed:..... Date.....

**To be completed upon admission**

Has there been any change in your health since completing the questionnaire? Y / N

Have you been well in the past month? If not, please outline changes or health problems .....  
.....

**Any alterations to be annotated in red pen and signed by patient**

Signature of Patient ..... Date.....

Signature of Admitting Nurses ..... Date.....

Patient ID