Braemar Hospital

BRAEMAR HOSPITAL TO AFFIX
PATIENT DETAILS LABEL HERE

PRE-ADMISSION FORM BHL-PAF/04E

Please complete this form online at www.braemar.co.nz/preadmission. Or scan and email the hardcopy form to preadmissionservice@braemarhospital.co.nz, or deliver it to us at 28 Ohaupo Road, Hamilton in the next two days.

As advised by your surgeon's rooms

Date of admission: ..... **Time of admission:** .....

Nothing to eat from: ..... Nothing to drink from: .....

Legal Surname: ..... Miss ☐ Ms ☐ Mrs ☐ Mr ☐ Dr ☐ Mx ☐

Legal First Names: ..... Preferred Name: .....

Date of Birth: ..... Country of Birth: .....

Gender/Pronouns: ..... Are you a permanent NZ resident?: Yes ☐ No ☐

Ethnicity: .....

Home Address: .....

Postal Address: .....

(if different to home)

Phone 1: ..... Phone 2: .....

Email: ..... Email Invoice? Yes ☐ No ☐

Surgeon or Specialist: .....

GP's Name: ..... Practice: .....

Next of Kin

Name: ..... Relationship: .....

Address: .....

Contact Phone Numbers: .....

Contact Person (if different from above)

Name: ..... Relationship: .....

Address: .....

Contact Phone Numbers: .....

Medical Insurance Company: ..... Approval Number: .....

ACC Approval Number: .....

Have you been treated in this hospital previously? Yes ☐ No ☐ Name previously used: .....

Do you require "Boarder" accomodation for an adult with a child patient? Yes ☐ No ☐

Braemar Hospital is unable to accept any responsibility for loss or damage to valuables or money belonging to patients.

Health Questionnaire - Please answer all health questions

Do you have, or have you ever had, any of the following?

If yes, please provide details below

	Yes	No
High blood pressure controlled with medication		
Heart attack		
Heart murmur		
Artificial heart valve		
Chest pains / Angina		
Coronary angiogram or stents in heart		
Rheumatic Fever		
Atrial Fibrillation / Palpitations / Arrythmias		
Cardiac devices eg: pacemaker, ICD		
COPD / Emphysema		
Asthma		
Have you had a head cold, throat / chest infection in the last 4 weeks?		
Persistent cough / croup		
Shortness of breath		
Severe snoring		
Obstructive Sleep Apnoea		
Covid 19		
Stroke / TIA		
Anaemia / Bleeding disorders		
Blood clots in legs or lungs (DVT / PE)		
Family history of blood clots		
In the last 6 weeks have you been on a long distance flight?		
Epilepsy / Seizure		
Blackouts / Fainting		
Migraines / Severe headaches		

	Yes	No
Heartburn / Reflux		
Diabetes: Type 1		
Diabetes: Type 2		
Thyroid problems		
Kidney problems		
Hepatitis		
Cirrhosis		
HIV / AIDS		
Tuberculosis		
Mental illness		
Anxiety		
Post-Traumatic Stress Disorder (PTSD)		
Depression		
Dementia / Alzheimer's		
Arthritis		
Joint implants or metal ware		
Have you had any falls in the last 6 months?		
Is your activity currently restricted by pain?		
Bowel conditions		
Bladder conditions including current / recent urine infection		
Current skin problems eg: ulcers, wounds, eczema, boils, pressure areas		
Do you currently use:		
Crutches / Walking stick		
Walker / Frame		
Wheelchair		

	Yes	No
Have you suffered post op nausea and vomiting with recent surgeries?		
Do you experience motion sickness?		
Have you or a blood relative ever had any problems during or after anaesthesia? eg: Malignant Hyperthermia, Muscular Dystrophy		
Can you easily climb 1 flight of stairs?		
Can you easily climb 2 flights of stairs?		
Difficulty opening your mouth?		
Are you, or could you be pregnant?		
Do you or have you ever smoked / vaped?		
If yes, how much?		
For how long?		
When did you give up?		
Do you drink alcohol?		
If yes, how many units weekly (1 standard glass wine or 1/2 glass beer = 1 unit)		
Do you use recreational drugs?		
If yes, what do you use?		
How often do you use?		
Do you wear glasses / contact lenses		
Do you have any other eye conditions		
Do you have hearing difficulties		
Any special dietary requirements?		
If yes, what:		
Do you have a disability?		
If your surgery requires the removal of body parts, would you like them returned to you if possible?		

If you answered **YES** to any of the questions above, please provide details, including treatment.

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Have you had previous surgery? If **YES**, please provide details.

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Have you been in a hospital or health care facility overseas in the last 6 months? **Yes** **No**

Have you been in a hospital or health care facility in New Zealand where an outbreak of antibiotic resistant organisms (MRSA, ESBL, etc) was reported? **Yes** **No**

Have you previously been found to be infected or colonised with MRSA, ESBL, VRE? **Yes** **No**

If **YES**, please provide details .....

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Do you have any other medical conditions not already covered, or is there anything else we should know about you eg: Parkinson's, muscle nerve disease, currently breastfeeding, etc? **Yes** **No**

If **YES**, please provide details .....

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Are you under medical specialist care eg: cardiologist, oncologist, rheumatologist? **Yes** **No**

If **YES**, please provide details .....

When did you last see them .....

Do you currently live alone? **Yes** **No**

If **YES**, who is going to support and care for you on discharge? .....

Do you have any religious or spiritual beliefs / practices or cultural needs we should be aware of? **Yes** **No**

If **YES**, please provide details .....

Do you have difficulty understanding English? **Yes** **No**

If **YES**, what is your preferred language .....

Is there anything we need to know that you prefer not to write on this questionnaire? **Yes** **No**

If **YES**, we will contact you prior to your admission.

Height ..... cm **Weight** ..... kg **DO NOT leave this blank**. If you do not know, please provide an estimate.

Have you ever had an allergic reaction or an adverse reaction to any drugs, iodine, sticking plaster, food etc?

Substance	**Reaction**

Please list **ALL** medicines – tablets, inhalers, patches etc prescribed by your doctor or over the counter (include any herbal or natural remedies).

Name of medication	**Dose**	**Frequency**

General Privacy Statement

We collect your health information to provide you with appropriate care and to monitor quality.
We share this information with other health care providers and agencies involved in your care.
We treat your information as confidential and ensure that it is kept secure and only accessed by authorised persons.
You have the right to request access to your records and to request correction of the information. Information may be supplied to family, support people or other agencies if you give us your permission or disclosure is authorised by law.
Our full Privacy Statement is available on our website or from the hospital reception.

Account Information

Statement to be signed by patient before surgery.

I understand and agree that:

- Unless my specialist has advised me otherwise, any hospital fee figure given to me is an estimate only. For example, a procedure may take a shorter or longer time to complete, or, you may require a longer stay in hospital than originally estimated. In most cases though your specialist will be able to provide you with a reasonably accurate estimate.
- I am responsible for the payment of all costs associated with my stay at Braemar Hospital (excluding those which are paid for by another organisation such as ACC, an insurance company, a district health board etc).
- If I am an ACC patient, I will be invoiced for costs not paid by ACC, such as telephone calls, room upgrades, extra meals etc.

Before the procedure

- I give permission for Braemar Hospital to check on my current credit status before (or after) my procedure.
- If I have no insurance cover or no prior approval from my insurance company, Braemar Hospital may reserve the right to insist that I pay an estimate of the cost of my procedure in advance. (Braemar Hospital recommends that you obtain prior approval from your insurance company).

Invoice and payment

Unless another organisation such as ACC or a district health board are paying the full amount, I will receive invoices from:

- Braemar Hospital, the specialist, the anaesthetist (where applicable), and any other services such as physiotherapy (where applicable).

If I have insurance cover for my procedure, I agree to promptly:

- Send the invoice to the insurance company.
- I agree to Braemar Hospital making the claim on my behalf for the hospital costs directly with my insurance provider where possible
- Pay for all of the cost of the procedure that is not paid by my insurance company.

If I do not have insurance cover:

- I will pay the account in full promptly on receipt of invoice.

Overdue accounts

- I agree that I have sufficient funds in place to meet the costs of my procedure at Braemar Hospital on the due date.

If I do not pay on the due date:

- I will pay the interest charged by Braemar Hospital on any amount unpaid after the due date.
- The interest rate will be 1% per month of the amount unpaid at the end of each month.
- Braemar Hospital may instruct their debt collector or solicitor to recover any amount unpaid after the due date.
- I will pay for all of the debt collection costs incurred by Braemar Hospital or their debt collector and/or legal costs on a solicitor/client basis

I, Patient ☐ Parent ☐ Caregiver ☐

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have read and accept the above terms.

Signature: .....

Date: .....

(to be signed at Braemar Hospital)

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PATIENT EMAIL LABEL HERE