Braemar Hospital
Your choice for excellence

BRAEMAR HOSPITAL TO AFFIX PATIENT DETAILS LABEL HERE

PRE-ADMISSION FORM

BHL-PAF/04E

As advised by your Surgeons rooms

Date of Admission: .... **Time of Admission:** ....

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

Please choose from one of the following two options:

1. This is a **fillable form**. The blank form must be **downloaded and saved before you fill it in**. Please email the completed form to **admissions@braemarhospital.co.nz**.
2. If you print the form to complete please then scan all pages, save as a PDF, and email to **admissions@braemarhospital.co.nz**. Please bring the original form with you on the day.

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

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

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

Female ☐ Male ☐ Are you a permanent NZ resident?: Yes ☐ No ☐

Occupation: .... Religion: (optional) ....

Ethnicity: ....

Home Address ....

Postal Address ....
(If different to Home)

Home Phone: .... Mobile: .... Business: ....

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" accommodation 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.

PLEASE REPORT TO: Braemar Hospital, 24 Ohaupo Road, Hamilton. Phone 07 843 1899

Name: .... DOB: ....

HEALTH QUESTIONNAIRE TO BE COMPLETED BY THE PATIENT

FAMILY HISTORY HAS ANY OF YOUR BLOOD RELATIONS EVER HAD:

YES	NO	Bleeding or clotting disorders	YES	NO	Inherited muscular disorder

PERSONAL HISTORY HAVE YOU EVER HAD OR DO YOU HAVE:

YES NO **ALLERGIES or SENSITIVITIES**
Have you ever had an allergic reaction or been sensitive to any drugs, iodine, sticking plaster, foods etc?

Sensitivity or Allergy *Drug/Medication/Substance*	**Nature of Reaction** *ie Rash/Swelling/Anaphylaxis/Diarrhoea*	**Severity** *Mild/Moderate/Severe*

YES	NO	Anaemia	YES	NO	Heart attack/angina/chest pain
YES	NO	Any antibiotic resistant infection	YES	NO	Hepatitis A, B or C
YES	NO	Arthritis	YES	NO	High blood pressure
YES	NO	Asthma	YES	NO	HIV
YES	NO	Blackouts or severe headaches	YES	NO	Kidney disease
YES	NO	Bladder infections	YES	NO	Neuromuscular illness
YES	NO	Bleed or bruise easily	YES	NO	Rheumatic fever
YES	NO	Blood clots in the legs or lungs	YES	NO	Shortness of breath
YES	NO	Cough or bringing up sputum	YES	NO	Sight impairment
YES	NO	Convulsions or fits	YES	NO	Stroke
YES	NO	Diabetes	YES	NO	Swollen ankles
YES	NO	Epilepsy	YES	NO	Tuberculosis
YES	NO	Hearing difficulties	YES	NO	Unusual thumping or beating of the heart
YES	NO	Do you snore?	YES	NO	Do you stop breathing when you sleep and/or have sleep apnoea?
YES	NO	Other illnesses (please specify)	YES	NO	Problems with anaesthetics (please specify)

YES	NO	Previous surgery (please specify)

YES	NO	Do you smoke?	How many cigarettes per day?
YES	NO	Do you drink alcohol?	How many alcoholic drinks per day?
YES	NO	Do you use recreational drugs?	What and how often?

YES	NO	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?
YES	NO	Have you been in contact with measles, mumps or chicken pox in the last 2 weeks?

YES	NO	Do you have any physical, emotional, spiritual, cultural, dietary or communication needs that we need to know about? If yes, please specify.
YES	NO	Have you had any falls in the past 6 months
YES	NO	**Females** - is there a possibility you might be pregnant? (X-rays during surgery or anaesthetic drugs may cause harm to your baby) How many weeks / months? When was your last period?
YES	NO	Is there anything else we need to know about you or your medical history or individual needs that will help us to plan the best care for you? If so please specify.

Name: .... DOB: ....

MEDICINES, TABLETS, INHALERS, INJECTIONS

Please list all the medications you have taken over the last 4 weeks - including homeopathic remedies, traditional treatments, hormonal or contraceptive medications.

Tablets, Inhalers, injections	Dose	How often	Are you currently taking it?

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.
- 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 ☐

....

have read and accept the above terms.

Signature: ....

Date: ....

(To be signed at Braemar Hospital)

BRAEMAR HOSPITAL TO
AFFIX PATIENT EMAIL LABEL HERE