

Important!

If you will be attending an anaesthetist clinic prior to admission, please take this completed form and the Health Questionnaire with you.

Otherwise deliver, post, fax or email these forms, together with the completed Admission Form 7-10 working days before your admission to:

Royston Hospital
500 Southland Road
Hastings 4122
Fax (06) 873 1189
Email hospital@royston.co.nz

} A stamped, addressed envelope is provided

If this is not possible, please make sure you bring the forms with you when you arrive for admission. If you faxed or emailed the forms to us, please bring the originals with you.

Admission Day	M	T	W	T	F	S	S	(circle one)	Admission Date	<input type="text"/>
Admission Time	<input type="text"/>		Scheduled date of Operation/Procedure		<input type="text"/>					

Personal Details (patient to complete)

Patient Name

Mr/Mrs/Ms/Miss/Dr

Surname

Given Names

Preferred Name

Date of Birth

Age

NHI No.

Known as

Address

Postcode:

Request for and Consent to Anaesthesia

(do not sign until you have been assessed by your anaesthetist)

I (patient or guardian)

Print Name

have had explained to me the anaesthetic

requirements associated with the procedure(s) as listed overleaf including the inherent benefits and risks of:

General Anaesthesia

Epidural / Spinal Anaesthesia

Local Anaesthesia

Intravenous Sedation

Regional Nerve Block

I accept the recommendation of Dr

Print Name

regarding these options.

Patient / Guardian

Signature

Date

Anaesthetic Specialist

Signature

Date

Please turn over for Medical and Surgical Treatment consent

Operation/Procedure (specialist to complete)

Diagnosis		
Operation / Procedure		
Approximate length of stay:	Hours <input type="text"/>	Nights <input type="text"/>
Admitting Specialist	<input type="text"/> Print Name	

Request for and Consent to Medical and Surgical Treatment

(patient to complete after consultation with Specialist)

I (patient or guardian) Print Name agree that I have had an explanation to my satisfaction of the intent, risks and likely outcomes of the operation/procedure/treatment I am receiving.

I consent to having blood tested for HIV / Hepatitis B / Hepatitis C in the event of a staff member or doctor is exposed to my blood Yes No

I am aware that I may ask for more information about treatment at any time.

I accept the advice of my specialist and ask that the above treatment be carried out.

Patient / Guardian	<input type="text"/> Signature	<input type="text"/> Date
Admitting Specialist	<input type="text"/> Signature	<input type="text"/> Date

Consent for Blood Products (patient to complete after consultation with Admitting Specialist)

I consent to receiving the following

I do not consent to receiving

I have been provided with the NZBS leaflet and all my questions have been answered to my satisfaction: Yes No

Patient / Guardian	<input type="text"/> Signature	<input type="text"/> Date
Specialist who has explained information in relation to the administration of blood components / blood products	<input type="text"/> Signature	<input type="text"/> Date

This consent is valid for six months.

Advance Directive (patient to complete if required)

Please tick appropriate boxes and provide a copy

Living Will / Advance Directive Enduring Power of Attorney Do Not Resuscitate Order