

## Completing and Submitting your Admission Forms and Health Questionnaire

Attending an anaesthetic clinic?	Return Forms 2 and 4 to Royston Hospital no later than <b>10 working days</b> prior to your procedure. Take Form 1 and Form 3 to your appointment, then return these forms to Royston Hospital.
Not attending an anaesthetic clinic?	Return all four forms to Royston Hospital no later than <b>10 working days</b> prior to your procedure: <b>DELIVER/COURIER</b> or <b>POST</b> Royston Hospital, 500 Southland Road, Hastings 4122 (envelope provided) or <b>FAX</b> (06) 873 1189 or <b>EMAIL</b> admissions@royston.co.nz <b>If you faxed or emailed the forms to us, please bring the originals with you on admission.</b>

Admitting Specialist	<input type="text"/>	Admission Date	<input type="text"/>
Admission Time	<input type="text"/>	Operation Date	<input type="text"/>

### PATIENT DETAILS (specialist to complete)

Affix Patient Label, or provide Patient Name/DOB/Address          NHI No. <input type="text"/>	<b>ADMISSION TYPE</b>  <input type="checkbox"/> DAY SURGERY UNIT (DSU) <input type="checkbox"/> DAY CASE (Ward Bed) <input type="checkbox"/> INPATIENT <input type="text"/> NIGHTS
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### OPERATION/PROCEDURE (specialist to complete)

Operative side of body: Left / Right / Bilateral / N/A (please circle)	
Estimated Theatre Time <input type="text"/> Mins	
Diagnosis <input type="text"/>	
History of DVT, PE, anticoagulation, diabetes etc <input type="text"/>	

### SPECIAL REQUIREMENTS: Enter on Page 2 and complete Clearance Assessment on Page 3

### REQUEST FOR AND CONSENT TO MEDICAL AND SURGICAL TREATMENT

(patient to complete after consultation with specialist)

I (patient or guardian of patient)	<input type="text"/> Print Name		
agree that I have had an explanation to my satisfaction of the intent, risks and likely outcomes of the operation/procedure/treatment on myself or my dependant.			
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	<input type="checkbox"/>	Yes	<input type="checkbox"/> No
I understand and agree that photographic images may be made and stored confidentially as part of my health record for this episode of care	<input type="checkbox"/>	Yes	<input type="checkbox"/> 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"/> Print Guardian Name (if applicable)	<input type="text"/> Date
Admitting Specialist	<input type="text"/> Signature	<input type="text"/> Date	

# CONSENT: Form 1

Patient Name:

Surname

Given names

Date of Birth:

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Admitting Specialist	<input type="text"/>	Admission Date	<input type="text"/>
Admission Time	<input type="text"/>	Operation Date	<input type="text"/>

### PATIENT DETAILS (specialist to complete)

Affix Patient Label, or provide  
Patient Name/DOB/Address

NHI No.

### ADMISSION TYPE

- ☐ DAY SURGERY UNIT (DSU)
- ☐ DAY CASE (Ward Bed)
- ☐ INPATIENT  NIGHTS

### OPERATION/PROCEDURE (specialist to complete)

Operative side of body: Left / Right / Bilateral / N/A (please circle)

Estimated Theatre Time  Mins

Diagnosis

History of DVT, PE, anticoagulation, diabetes etc

### SPECIAL REQUIREMENTS:

### REQUEST FOR AND CONSENT TO MEDICAL AND SURGICAL TREATMENT

(patient to complete after consultation with specialist)

I (patient or guardian of patient)	<input type="text"/>	Print Name
agree that I have had an explanation to my satisfaction of the intent, risks and likely outcomes of the operation/procedure/treatment on myself or my dependant.		
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	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I understand and agree that photographic images may be made and stored confidentially as part of my health record for this episode of care	<input type="checkbox"/> Yes	<input type="checkbox"/> 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"/>	Print Guardian Name (if applicable)
	<input type="text"/>	Date
Admitting Specialist	<input type="text"/>	Signature
	<input type="text"/>	Date

Patient Name:

Surname

Given names

Date of Birth:

Affix Patient Label, or provide  
Patient Name/DOB/Address/NHI No

## CLEARANCE ASSESSMENT (specialist to complete)

### MRSA

- Yes / No Resident in a rest-home or long term care facility, excluding independent units?
- Yes / No Employed or admitted to a hospital in NZ or Overseas in the last 6 months?
- Yes / No Previous history of MRSA colonisation or infection?

If YES to one or more criteria, refer to Royston Protocol IFPR501

☐ tick

### ESBL

- Yes / No Admitted to an Overseas hospital in the last 6 months?
- Yes / No Treated in a health facility in Pakistan or Indian sub-continent in the last 6 months?
- Yes / No Indwelling catheter in-situ for >2 weeks?
- Yes / No Previous history of ESBL colonisation or infection?

If YES to one or more criteria, refer to Royston Protocol IFPR518

☐ tick

## REQUEST FOR AND CONSENT TO ANAESTHESIA (patient to sign after being assessed by anaesthetist)

I (patient or guardian of patient)

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

## CONSENT FOR BLOOD PRODUCTS (patient to complete after consultation with admitting specialist)

Consent given to receiving

Consent not given to receiving

I have been provided with the NZBS leaflet and all my questions have been answered to my satisfaction:

☐

Yes

☐

No

Patient / Guardian

Signature

Date

Specialist who has explained information in relation to the administration of blood components / blood products

Signature

Date

## ADVANCE DIRECTIVE (patient / guardian to complete if required)

If you tick any of these boxes please provide a copy of the document/s

☐

Living Will / Advance Directive

☐

Enduring Power of Attorney  
For Health & Welfare

☐

Do Not Resuscitate  
Order