CONSENT: Form 1

ROYSTON HOSPITAL

Completing and Submitting your Admission Forms and Health Questionnaire

Attending an anaesthetic clinic?	Return Forms 2 and 4 to Royston Hospital no later than **10 working days** 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 **10 working days** prior to your procedure: **DELIVER/COURIER** or **POST** Royston Hospital, 500 Southland Road, Hastings 4122 (envelope provided) or **FAX** (06) 873 1189 or **EMAIL** admissions@royston.co.nz **If you faxed or emailed the forms to us, please bring the originals with you on admission.**

Admitting Specialist _____ Admission Date _____

Admission Time _____ Operation Date _____

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 ☐ Diabetic ☐ ↑ BMI ☐ Disability ☐ Other _____

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) 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 ☐ Yes ☐ 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 ☐ 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 Signature Print Guardian Name (if applicable) Date

Admitting Specialist Signature Date

CONSENT: Form 1

Patient Name: _____
Surname *Given names*

Date of Birth: _____

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Admitting Specialist		Admission Date	
Admission Time		Operation Date	

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Patient / Guardian	Signature	Print Guardian Name (if applicable)	Date
Admitting Specialist	Signature		Date

Patient Name:

Surname *Given names*

Date of Birth:

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

INPATIENT CLEARANCE ASSESSMENT (specialist to complete)

MRSA

Yes / No Resident in a rest-home or long term care facility, excluding independent units?

Yes / No Clinically employed in a hospital or rest home in the last 6 months?

Yes / No Admitted to a hospital in NZ or Overseas for more than 24 hours and has had surgery or an invasive procedure (eg PICC line insertion) in the last 6 months?

Yes / No Previous history of MRSA colonisation or infection?

If YES to one or more criteria swab patient.
Day Surgery patients are excluded.

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 swab patient.
Day Surgery patients are excluded.

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)

A copy of the directive is attached ☐