

## **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 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)								
			DAY SURGERY UNIT (DSU)  DAY CASE (Ward Bed)					
	NHI No.			TENT				
OPERATION/PRO	OCEDURE (specialist to comple	ete)						
Operative side of I	body: Left / Right / Bilateral	/ N/A (please circle)						
Estimated Theatre Time Mins								
Diagnosis	Diagnosis							
☐ History of DVT/PE/Anticoagulation ☐ Diabetic ☐ ♠ BMI ☐ Disability ☐ Other								
	E/Anticoagulation Diabetic	c	sability 🔲 (	Other				
	EMENTS: Enter on Page 2				on Page 3			
SPECIAL REQUIR		and complete Cle	earance Ass	sessment o	on Page 3			
SPECIAL REQUIR	EMENTS: Enter on Page 2  ND CONSENT TO MEDICAL e after consultation with specia	and complete Cle L AND SURGICAL alist)	earance Ass	sessment o	on Page 3			
SPECIAL REQUIRE REQUEST FOR AN (patient to complete) I (patient or guarding agree that I have here)	EMENTS: Enter on Page 2  ND CONSENT TO MEDICAL e after consultation with specia	and complete Cle L AND SURGICAL alist)  Printer faction of the intent,	earance Ass TREATMEN	sessment o				
SPECIAL REQUIRE  REQUEST FOR AN (patient to complete)  I (patient or guard)  agree that I have hoperation/procedu I consent to having	EMENTS: Enter on Page 2  ND CONSENT TO MEDICAL e after consultation with special ian of patient) had an explanation to my satisf	and complete Cle L AND SURGICAL alist)  Printed faction of the intent, dependant. tis B / Hepatitis C	earance Ass TREATMEN	sessment o				
SPECIAL REQUIRE  REQUEST FOR AN (patient to complete)  I (patient or guard)  agree that I have hoperation/procedu  I consent to having in the event of a still understand and a	EMENTS: Enter on Page 2  ND CONSENT TO MEDICAL e after consultation with special ian of patient) and an explanation to my satisf re/treatment on myself or my of	and complete Cle L AND SURGICAL alist)  Print faction of the intent, dependant. tis B / Hepatitis C tied to my blood tes may be made	TREATMEN  TREATMEN  TREATMEN  TREATMEN	sessment o	of the			
SPECIAL REQUIRE  REQUEST FOR AN (patient to complete of a gree that I have hoperation/procedured of a standard of	EMENTS: Enter on Page 2  ND CONSENT TO MEDICAL e after consultation with special ian of patient)  and an explanation to my satisf re/treatment on myself or my or g blood tested for HIV / Hepatit caff member or doctor is exposingree that photographic image	faction of the intent, dependant.  tis B / Hepatitis C and to my blood as may be made cord for this episode about treatment at an about treatment at an armonic cord for the c	TREATMEN  TREATMEN  TREATMEN  TREATMEN  TREATMEN  TREATMEN	sessment of T  Ily outcomes  Yes  Yes	of the			
SPECIAL REQUIRE  REQUEST FOR AN (patient to complete of a gree that I have hoperation/procedured of a standard of	EMENTS: Enter on Page 2  ND CONSENT TO MEDICAL e after consultation with special ian of patient)  nad an explanation to my satisf re/treatment on myself or my or g blood tested for HIV / Hepatit caff member or doctor is exposingree that photographic image entially as part of my health received	faction of the intent, dependant.  tis B / Hepatitis C and to my blood as may be made cord for this episode about treatment at an about treatment at an armonic cord for the c	TREATMEN  TREATMEN	Sessment of T  If outcomes  Yes  Yes  t.	of the			

## **CONSENT: Form 1**

Patient Name:				
	Surname		Given names	
	D	ate of Birth:		

Completing and	Submitting your Adm	nission Forms a	nd Health	Questio	nnaire		
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.						
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Admitting Specialist	Admission Date						
Admission Time	Operation Date						
PATIENT DETAILS	(specialist to complete)						
		DAY SURGERY UNIT (DSU)  DAY CASE (Ward Bed)					
	NHI No.		INPAT	ENT	NIGHTS		
OPERATION/PRO	CEDURE (specialist to comple	ete)					
Operative side of body: Left / Right / Bilateral / N/A (please circle)  Estimated Theatre Time Mins							
Diagnosis							
☐ History of DVT/P	E/Anticoagulation Diabetic	☐ ↑ BMI ☐ Dis	sability 🔲 C	Other			
SDECIAL DECLIER	EMENTS:						
SPECIAL REQUIREMENTS:  REQUEST FOR AND CONSENT TO MEDICAL AND SURGICAL TREATMENT (patient to complete after consultation with specialist)							
I (patient or guardi	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							
	gree that photographic images		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						
Admitting Specialis	s <b>t</b> Sig						

Patient Na	me:									
Surname Given names		Affix Patient Label, or provide								
	Date of Birth:			Patient Name/DOB/Address/NHI No						
INPATIE	NT CLEARANCE A	ASSESSMEN <sup>®</sup>	T (specialist to	complete)						
MRSA				ESBL						
Yes / No Resident in a rest-home or long term care facility, excluding independent units?		Yes / No Admitted to a last 6 months			nn Overseas hospital in the ?					
Yes / No	rest home in th	Clinically employed in a hospital or rest home in the last 6 months?		Yes / No	'es / No Treated in a health facility in Pakistan of Indian sub-continent in the last 6 months.					
Yes / No	for more than surgery or an i	Admitted to a hospital in NZ or Overseas for more than 24 hours and has had surgery or an invasive procedure (eq PICC line insertion) in the last 6 months?		Yes / No Yes / No	Indwelling catheter in-situ for >2 weeks? Previous history of ESBL colonisation or infection?					
Yes / No	No Previous history of MRSA colonisation or infection?				If YES to one or more criteria swab patient. <u>Day Surgery patients are excluded.</u>					
If YES to one or more criteria swab patient. <u>Day Surgery patients are excluded.</u>										
REQUES	T FOR AND CON	SENT TO AN	IAESTHESIA	(patient to sig	ın after being	g asse	essed by ana	esthe	tist)	
I (patier	I (patient or guardian of patient)				t Name had explained to me			o me the		
anaesthe	etic requirements ass	ociated with th	ne procedure(s) a	as listed overlea	af including th	ne inł	nerent bene	fits and	d risks of:	
				/ Spinal Anae	Spinal Anaesthesia			Local Anaesthesia		
	Intravenous Sedat	ion	Regiona	l Nerve Block						
I accept	the recommendation	on of Dr					regarding these options.			
Patient / Guardian										
Anaesthetic Specialist										
CONSEN	IT FOR BLOOD P	RODUCTS (p	atient to comp	lete after cons	sultation with	n adn	nitting spec	ialist)		
Consent	given to receiving									
Consent	t <u>not</u> given to receiv	ing								
I have been provided with the NZBS leaflet and all my questions have been answered to my satisfaction:				Yes		No				
Patient / Guardian Signature										
in relati	t who has explained information on to the administration of omponents / blood products									
ADVAN	CE DIRECTIVE (pa	atient / guardia	an to complete	if required)						
A copy of	of the directive is at	tached								