

## Payment details

Self-funded  Medical insurance Name of company:   
Policy number:

**Self-funded/medical insurance only:** I agree that I am responsible for and will pay all costs incurred in connection with my treatment that are not covered by other parties (i.e. Medical Insurance). Overdue accounts will incur dept collection fees.

Signature:  Print name (in full):

ACC ACC claim number:  ACC injury date:  /  /

Te Whatu Ora (Health NZ) – Te Tai Tokerau  Other - specify:

## Informed consent

To ensure you are provided the opportunity for informed consent, please read the following statement to indicate you agree to treatment.

I have had the opportunity to discuss and ask questions about my planned procedure with my doctor and fully understand the procedure and associated risks.  Yes  No

## Privacy of health information

Under the provisions of the Health Information Privacy Code 2020, there is a requirement to collect and store information about each patient to help provide good and safe treatment. It is mandatory to send certain health information to other organisations, such as the Ministry of Health. Your medical records will be kept secure and will only be accessed by authorised personnel. By law, we must retain your health records for ten years. You, as a patient, have the right of access to your notes during this time. Requests for access to your notes should be made via reception. If, for any reason, you require to be transferred to another hospital, a copy of your notes from Allevia Kensington Hospital will accompany you. A copy of the Health Information Privacy Code is available for further information if desired.

**I give permission to Allevia Kensington Hospital or any health professional involved in my care for this admission to hospital, to access health information about me that is relevant to my current treatment, which may be held by Allevia Kensington Hospital, other health professionals or other health organisations.**

Signature:  Date:  /  /

Print name (in full):

The above details have been completed by:

Patient  Guardian  Relative  Other (specify):

Please complete and return **seven days prior to admission** to: [reception@alleviakensington.co.nz](mailto:reception@alleviakensington.co.nz) or deliver to our reception.

**Allevia  
Kensington  
Hospital**

## Admission form

Please complete and return **seven days prior to admission** to: [reception@alleviakensington.co.nz](mailto:reception@alleviakensington.co.nz) or deliver to our reception

AFFIX PATIENT LABEL HERE

**Allevia  
Kensington  
Hospital**

### Admission details (for office use only)

Date of operation:  /  /  Time:  AM/PM NHI number:   
Surgeon:  Proposed surgery:   
Anaesthetic Type:  LA  GA  Sedation Anaesthetist:

### Patient details

First name(s):   
Surname:   
Preferred name:   
Gender:  Male  Female  Other - specify:  Age:   
Date of birth:  /  /  Your height:  cm Your body weight:  kg  
Physical address:   
Postal address:   
Phone number: (Mobile):  (Other):   
Email:   
Your GP: (Name):  (Practice):   
Are you a NZ resident:  Yes  No Ethnicity:   
Is English your first language?  Yes  No Interpreter required:  Yes  No  
What is your personal goal for having this planned procedure?  
  
Have you stayed overnight in a hospital (New Zealand or overseas), rest home or prison, in the last 12 months?  
 No  Yes - specify when and where:

### Emergency contact person/next of kin

Name:  Relationship to patient:   
Phone number: (Mobile):  (Other):

### Discharge details

If you are a Day Stay patient – please provide the details of the responsible adult who is staying with you overnight after general anaesthetic or sedation? (must be 16 years or older)

Contact person:  Phone number:

Have you arranged someone to take you home on discharge?  Yes  No

Contact person:  Phone number:

## Anaesthetics

Do you have any allergies?

Yes, please list: 

Allergen	Type of reaction

 No

Have you had an anaesthetic?  Yes  No

If 'yes', what type of anaesthetic have you had?  General  Spinal or Epidural

Have you had any problems with an anaesthetic?

Yes - please provide details:   No

Do you have any problems opening your mouth, or do you have a stiff neck?  Yes  No

Do you have reflux or heartburn?  Yes  No

Do you drink alcohol?  Yes - how much:   No

Do you smoke cigarettes or vape?  Yes - how often:   No

Do you regularly use recreational drugs?  Yes - what and how often:   No

## Health and support questionnaire

Do you have or have you had any of the following respiratory conditions? Select all that apply.

Asthma  Emphysema  Persistent cough  None of the above  
 Tuberculosis  Bronchitis  Obstructive sleep apnoea

Have you had any respiratory illness within the last three months? (e.g. COVID-19, RSV, Influenza)

Yes - are you still experiencing residual symptoms?   No

Do you use a CPAP machine?  Yes  No

Do you have or have you had any of the following cardiac conditions? Select all that apply.

High blood pressure  Artificial heart valve  Irregular heart rate or Atrial Fibrillation (AF)  
 Stroke / Transient Ischemic Attack (TIA)  Pacemaker  Other - please provide details:   
 Heart attack  Coronary/heart stents  None of the above  
 Heart murmurs  Rheumatic fever

Do you have or have you had any of the following blood conditions? Select all that apply.

Anaemia  Blood clots or Deep Vein Thrombosis (DVT)  Other - please provide details:   
 Bleeding disorder  Blood transfusion  None of the above

Do you have or have you had any of the following medical conditions? Select all that apply.

Kidney/renal disease  Malignant hyperthermia  Other - please provide details:   
 Muscle or nerve disease  Epilepsy  None of the above  
 Arthritis  Fainting or blackouts

Do you have diabetes?  Yes  No

If 'yes', what type of diabetes do you have?  Type 1  Type 2

How do you manage your diabetes?  Insulin  Tablets  Diet controlled

Do you have any problems with your bladder? (i.e. frequent infections, incontinence, urinary catheter, other)

Yes - please provide details:   No

Do you have any problems with your bowels? (i.e. IBS, Crohn's, constipation, stoma, other)

Yes - please provide details:   No

Do you have any of the following mental health conditions? Select all that apply.

Dementia  Phobia  None of the above  
 Anxiety  Other - please provide details:

Do you currently have any wounds or broken areas of skin? (e.g. cuts, rashes, eczema, boils, fungal infection, etc.)

Yes - please provide details:   No

Do you take any regular prescribed medications or over the counter medications/supplements?

Yes - please provide details:   No

Name of Drug	Dose	Frequency

Are you taking any anticoagulants or blood thinning medication?

Yes - which blood thinners are you taking?   No

Do you currently receive any community or home support services?

Yes - please provide details including what type of assistance and how often you receive support:   No

Do you use any of the following mobility aids? Select all that apply.

Walking stick  Walking frame  None of the above  
 Wheelchair - please provide details as to why:   
 Hoist - please provide details as to why:   
 Other - please provide details:

Do you have any special dietary requirements?

Yes - please provide details:   No

Do you have any cultural or spiritual needs?

Yes - please provide details:   No

Have you had any major surgical procedures or operations in the last 5 years?

Yes - please provide details:   No

Do you have any addition concerns or special requirements which you have not mentioned above? (e.g. dependents, live alone, pregnant, etc.)

Yes - please provide details:   No