Patient to complete all sections and return to the hospital
PRIOR TO ADMISSION to confirm your booking

Boulcott Hospital Admissions
PO Box 31459
Lower Hutt 5040
Phone: 569-7555 • Fax: 567-0041

Boulcott Hospital

ADMISSION FORM

Surname ..... Given Names ..... Mr/Mrs/Ms/Miss/Master

Preferred Name ..... Date of Birth..... Age..... Sex: M/F Ethnicity.....

Address ..... Postcode .....

Telephone (H) ..... (Bus) ..... (Mobile) .....

Family Doctor ..... NHI No (if known) .....

Emergency Contact Name ..... Relationship .....

Address .....

Telephone (Day) ..... (A/h) .....

Special Dietary Requirements (please state) .....

.....

Any other special needs – physical/cultural/spiritual/communication (please state) .....

.....

.....

Procedure: .....

.....

.....

Surgeon: ..... Admission Date: .....

Have your hospital treatment costs been approved by:

ACC: YES / NO If so, ACC No: .....

Medical Insurance: Policy No: ..... Approval No: .....

Name of Company: .....

Payment will be made by: (please tick) Credit Card ◯ Cheque ◯ Cash ◯ EftPos ◯

All costs are an APPROXIMATION only

HOSPITAL ADMINISTRATION ONLY

Consent form checked ..... Y ☐ ☐ N
Anaesthetist advised ..... Y ☐ ☐ N
Hospital advised ..... Y ☐ ☐ N
Hospital Notes/X-ray files available ..... Y ☐ ☐ N/A

Admission Clerk ..... Principal Nurse .....
(Signature) (Signature)

HEALTH QUESTIONNAIRE

It is important that you answer all questions as accurately as possible. All information is sought to minimise your risk and will be retained as part of your confidential clinical records

- **Do you suffer from, or have you ever suffered from, the following?** (circle Y for yes, N for no)

Chest pains/tightness or Angina ..... Y / N
Previous Rheumatic Fever ..... Y / N
Previous Heart Attack ..... Y / N
Palpitations ..... Y / N
Heart Murmur ..... Y / N
High Blood Pressure ..... Y / N
Artificial Heart Valve or Pacemaker ..... Y / N
Hiatus Hernina/Heartburn/Indigestion ..... Y / N
Rheumatoid Arthritis ..... Y / N
HIV/Aids ..... Y / N
Jaundice or Hepatitis ..... Y / N
Please specify type (if known) .....

Diabetes ..... Y / N
Insulin ☐ Oral Medication ☐ Diet Controlled ☐

Shortness of breath ..... Y / N
Asthma ..... Y / N
Emphysema or Bronchitis ..... Y / N
Tuberculosis ..... Y / N
Obstructive Sleep Apnoea ..... Y / N
Persistent Cough ..... Y / N
Kidney Disease ..... Y / N
Thyroid Disease ..... Y / N
Prostate Conditions ..... Y / N
Previous DVT or Lung Embolus ..... Y / N
Stroke or Seizures ..... Y / N
Paralysis/Impaired sensation ..... Y / N
Pressure areas/skin ulcers ..... Y / N
Thin/fragile skin that bruises/breaks easily ..... Y / N
Do you have wounds/broken skin at present ..... Y / N

- **If you have answered yes to any of the above, please give further details below**

.....
.....
.....
.....

- **Do you suffer from any other conditions, not covered elsewhere, that you feel we should know about?** If so, please outline Y / N

.....

- **Do you have any concerns or questions about your anaesthetic?** If so, please outline Y / N

.....

- **Have you been in any other hospital/resthome as a patient or staff member in the last 6 months?** Y / N
- **Have you ever been told you have MRSA, or other antibiotic resistant organism?** If so, please outline Y / N

.....

Your Weight: .....kg
Your Height: .....metres

Do you:

Smoke: Y / N How many? .....
Drink Alcohol: Y / N How much? .....
How often? .....

- **Have you ever had a reaction/allergy to any medications, tablets, plasters, food, latex/rubber or any other substances?** If so, please list Y / N

Substance	Type of reaction	Substance	Type of reaction
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

Patient ID

- **Please list previous hospital admission including year and hospital (if known)**

Reason for admission	Date	Hospital
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....

- **Please bring with you all medications/remedies/supplements in their original containers to the hospital and a current printout from your GP or pharmacy that includes dosage regime. If your medications are in a blister pack please bring the entire pack**

Medication	Dose	Time Taken	Medication	Dose	Time Taken
.....	.....	.....	.....	.....	.....
.....	.....	.....	.....	.....	.....
.....	.....	.....	.....	.....	.....
.....	.....	.....	.....	.....	.....
.....	.....	.....	.....	.....	.....
.....	.....	.....	.....	.....	.....
.....	.....	.....	.....	.....	.....
.....	.....	.....	.....	.....	.....

- **Do you have problems opening your mouth?** Y / N
- **Have you been told of previous problems with your airway under anaesthesia?** Y / N
- **Do you have any of the following:** (please tick those that apply)
  ◯ dentures ◯ partial plate ◯ capped or loose teeth
- **What physical activity(ies) do you take part in on a regular basis?** (please tick those that apply)
  ◯ walking ◯ gym work ◯ tennis ◯ golf ◯ others (list) _____
- **I can climb ◯ one ◯ two ◯ or more flights of stairs without getting short of breath**
- **My activity is restricted by:** (please tick those that apply)
  ◯ shortness of breath ◯ chest pain ◯ joint pain
- **Women only – Are you, or could you, be pregnant?** Y / N
- **Are there any major illnesses, to your knowledge, within your blood relatives eg; diabetes, muscular dystrophy, malignant hyperthermia etc?** If so, please outline Y / N

  .....

  .....

  .....
- **Have you or any of your family had problems with anaesthetic?** If so, please outline Y / N

  .....

  .....

The details above have been completed by: [PLEASE SIGN BELOW]

◯ **patient** ◯ **guardian** ◯ **relative** ◯ **or other?** (please tick)

Signed: ..... **Date:** .....

Patient ID

BH200

HEALTH QUESTIONNAIRE

Photographic Images:

I understand that photographic images may be taken before/during and/or after my treatment as part of my clinical management

Agree ◯ Disagree ◯

Teaching / Technical Support:

Medical / health related non medical personnel to be present during procedure

I understand that for teaching / technical support this may require the attendance of a medical or health related non medical person.

Agree ◯ Disagree ◯ Wish to discuss further ◯

Student nurses under the supervision of a Registered Nurse may be involved in my care

Agree ◯ Disagree ◯

Signed:..... Date.....

Health Information:

We need to collect and store some information about you: to comply with legislated requirements, to provide Government bodies with information to which they are legally entitled, and to help us provide safe treatment.

We undertake: only to collect information which is necessary for your treatment; only to use the information for its intended purposes; to keep the information securely in your medical file or in our computer system;
only to allow authorised staff to use that information; only to pass on to Government bodies that information to which they are legally entitled; to allow you to check the accuracy of any information about you and request an addition to that information as you feel appropriate.

Do we have your permission to communicate with your family doctor? Yes ◯ No ◯

Do we have your permission to share information with your family relating to this admission? Yes ◯ No ◯

If yes, information may be shared with .....

.....

I have read the above explanation and assurances and agree to the collection and storage of information.

Signed:..... Date.....

To be completed upon admission

Has there been any change in your health since completing the questionnaire? Y / N

Have you been well in the past month? If not, please outline changes or health problems .....

.....

Any alterations to be annotated in red pen and signed by patient

Signature of Patient ..... Date.....

Signature of Admitting Nurses ..... Date.....

Patient ID