



BRAEMAR HOSPITAL TO AFFIX
PATIENT DETAILS LABEL HERE

PRE-ADMISSION FORM BHL-PAF/04E

As advised by your surgeon's rooms

Date of admission: **Time of admission:**

Nothing to eat from: Procedure:

Nothing to drink from:

Please complete this form online:

- Once completed, save the completed form as a pdf
- Email the pdf to admissions@braemarhospital.co.nz at least 1 week prior to your admission

Legal Surname: Miss Ms Mrs Mr Dr Mx

Legal First Names: Preferred Name:

Date of Birth: Country of Birth:

Gender/Pronouns: Are you a permanent NZ resident?: Yes No

Ethnicity:

Home Address:

Postal Address:

(if different to home)

Phone 1: Phone 2:

Email: Email Invoice? Yes No

Surgeon or Specialist:

GP's Name: Practice:

Next of Kin

Name: Relationship:

Address:

Contact Phone Numbers:

Contact Person (if different from above)

Name: Relationship:

Address:

Contact Phone Numbers:

Medical Insurance Company: Approval Number:

ACC Approval Number:

Have you been treated in this hospital previously? Yes No Name previously used:

Do you require "Boarder" accomodation for an adult with a child patient? Yes No

Braemar Hospital is unable to accept any responsibility for loss or damage to valuables or money belonging to patients.

Health Questionnaire - Please answer all health questions

Do you have, or have you ever had, any of the following?

If yes, please provide details below

	Yes	No		Yes	No		Yes	No
High blood pressure controlled with medication	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn / Reflux	<input type="checkbox"/>	<input type="checkbox"/>	Have you suffered post op nausea and vomiting with recent surgeries?	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes: Type 1	<input type="checkbox"/>	<input type="checkbox"/>	Do you experience motion sickness?	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes: Type 2	<input type="checkbox"/>	<input type="checkbox"/>	Have you or a blood relative ever had any problems during or after anaesthesia? eg: Malignant Hyperthermia, Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valve	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	Can you easily climb 1 flight of stairs?	<input type="checkbox"/>	<input type="checkbox"/>
Chest pains / Angina	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	Can you easily climb 2 flights of stairs?	<input type="checkbox"/>	<input type="checkbox"/>
Coronary angiogram or stents in heart	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Do you have difficulty opening your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>	Are you, or could you be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Atrial Fibrillation / Palpitations / Arrhythmias	<input type="checkbox"/>	<input type="checkbox"/>	HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Do you currently smoke or vape?	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac devices eg: pacemaker, ICD	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Have you previously smoked or vaped regularly?	<input type="checkbox"/>	<input type="checkbox"/>
COPD / Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	When did you give up?	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a head cold, throat / chest infection in the last 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	Post-Traumatic Stress Disorder (PTSD)	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how many units weekly (1 standard glass wine or 1/2 glass beer = 1 unit)	<input type="checkbox"/>	<input type="checkbox"/>
Persistent cough / croup	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Do you use recreational drugs?	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Dementia / Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>	If yes, what do you use?	<input type="checkbox"/>	<input type="checkbox"/>
Severe snoring	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	How often do you use?	<input type="checkbox"/>	<input type="checkbox"/>
Obstructive Sleep Apnoea	<input type="checkbox"/>	<input type="checkbox"/>	Joint implants or metal ware	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear glasses / contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
Covid 19	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any falls in the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any other eye conditions?	<input type="checkbox"/>	<input type="checkbox"/>
Stroke / TIA	<input type="checkbox"/>	<input type="checkbox"/>	Is your activity currently restricted by pain?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have hearing difficulties?	<input type="checkbox"/>	<input type="checkbox"/>
Anaemia / Bleeding disorders	<input type="checkbox"/>	<input type="checkbox"/>	Bowel conditions	<input type="checkbox"/>	<input type="checkbox"/>	Any special dietary requirements?	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots in legs or lungs (DVT / PE)	<input type="checkbox"/>	<input type="checkbox"/>	Bladder conditions including current / recent urine infection	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a disability?	<input type="checkbox"/>	<input type="checkbox"/>
Family history of blood clots	<input type="checkbox"/>	<input type="checkbox"/>	Current skin problems eg: ulcers, wounds, eczema, boils, pressure areas	<input type="checkbox"/>	<input type="checkbox"/>	If your surgery requires the removal of body parts, would you like them returned to you if possible?	<input type="checkbox"/>	<input type="checkbox"/>
In the last 6 weeks have you been on a long distance flight?	<input type="checkbox"/>	<input type="checkbox"/>	Do you currently use:					
Epilepsy / Seizure	<input type="checkbox"/>	<input type="checkbox"/>	Crutches / Walking stick	<input type="checkbox"/>	<input type="checkbox"/>			
Blackouts / Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Walker / Frame	<input type="checkbox"/>	<input type="checkbox"/>			
Migraines / Severe headaches	<input type="checkbox"/>	<input type="checkbox"/>	Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>			

If you answered **YES** to any of the questions above, please provide details, including treatment.

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Have you had previous surgery? If **YES**, please provide details.

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General Privacy Statement

We collect your health information to provide you with appropriate care and to monitor quality.

We share this information with other health care providers and agencies involved in your care.

We treat your information as confidential and ensure that it is kept secure and only accessed by authorised persons.

You have the right to request access to your records and to request correction of the information. Information may be supplied to family, support people or other agencies if you give us your permission or disclosure is authorised by law.

Our full Privacy Statement is available on our website or from the hospital reception.

Account Information

Statement to be signed by patient before surgery.

I understand and agree that:

- Unless my specialist has advised me otherwise, any hospital fee figure given to me is an estimate only. For example, a procedure may take a shorter or longer time to complete, or, you may require a longer stay in hospital than originally estimated. In most cases though your specialist will be able to provide you with a reasonably accurate estimate.
- I am responsible for the payment of all costs associated with my stay at Braemar Hospital (excluding those which are paid for by another organisation such as ACC, an insurance company, a district health board etc).
- If I am an ACC patient, I will be invoiced for costs not paid by ACC, such as telephone calls, room upgrades, extra meals etc.

Before the procedure

- I give permission for Braemar Hospital to check on my current credit status before (or after) my procedure.
- If I have no insurance cover or no prior approval from my insurance company, Braemar Hospital may reserve the right to insist that I pay an estimate of the cost of my procedure in advance. (Braemar Hospital recommends that you obtain prior approval from your insurance company).

Invoice and payment

Unless another organisation such as ACC or a district health board are paying the full amount, I will receive invoices from:

- Braemar Hospital, the specialist, the anaesthetist (where applicable), and any other services such as physiotherapy (where applicable).

If I have insurance cover for my procedure, I agree to:

- Send the invoice to the insurance company.
- Braemar Hospital making the claim on my behalf for the hospital costs directly with my insurance provider where possible
- Pay for all of the cost of the procedure that is not paid by my insurance company.

If I do not have insurance cover:

- I will pay the account in full promptly on receipt of invoice.

Overdue accounts

- I agree that I have sufficient funds in place to meet the costs of my procedure at Braemar Hospital on the due date.

If I do not pay on the due date:

- I will pay the interest charged by Braemar Hospital on any amount unpaid after the due date.
- The interest rate will be 1% per month of the amount unpaid at the end of each month.
- Braemar Hospital may instruct their debt collector or solicitor to recover any amount unpaid after the due date.
- I will pay for all of the debt collection costs incurred by Braemar Hospital or their debt collector and/or legal costs on a solicitor/client basis

I, Patient Parent Caregiver

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have read and accept the above terms.

Signature:

Date:

(to be signed at Braemar Hospital)

BRAEMAR HOSPITAL TO AFFIX
PATIENT EMAIL LABEL HERE