

Please ensure all sections are completed fully so that we are able to meet your individual needs and deliver our promise of quality care.

Please return your **3** completed forms to Gillies Hospital as soon as possible, ensuring that they arrive **one week** before your admission.

These can be either posted, faxed (09 631-1901), or emailed to: [bookings@gillieshospital.co.nz](mailto:bookings@gillieshospital.co.nz) or hand delivered to the hospital. If faxing or emailing, please bring original forms on admission.

## Checklist

### Before coming into Hospital, have you ...

- Completed and returned your 3 forms to the Hospital
- Contacted your insurance company for "prior approval"
- Arranged transport to and from the Hospital
- Completed any special preparations

### Remember to bring your ...

- Patient information pack
- Insurance "prior approval" letter
- Anaesthetic Information Leaflet
- Current medications
- X-rays, scans or test results
- Doctor(s) letters
- Glasses/hearing aid

## Privacy

Any information and personal data gathered for the purpose of your visit to Gillies Hospital is to assist in your treatment, for quality assurance activities and to fulfil legislative requirements. Your rights provided in the Health Information Privacy Code and the Privacy Act 1993 will be respected including your right to access and if necessary, correct any information held about you. If you have any concerns, please contact the Hospital Manager who is the Privacy Officer.

More information on the Health Information Privacy Code and the Privacy Act 1993 can be found at <http://www.privacy.org.nz/health-information-privacy-code/>











Patient Name: \_\_\_\_\_

**Yes No**

Any other major illnesses or conditions?  
If **YES**, please specify: (e.g. Kidney or liver problems, Thyroid disease, Malignant Hyperthermia).  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever had any **allergic reactions** to latex, iodine, medications, plasters, food or any other substance?  
If **YES**, please list your **allergies** and describe the **reactions**:  
\_\_\_\_\_  
\_\_\_\_\_

Have you had an anaesthetic before?  
  Have problems opening mouth?  
  Have you or any other family member had any problems with an anaesthetic?  
If **YES**, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**List all procedures/operations you have had (start with the most recent).**

| Procedures/Operations | Year | Hospital |
|-----------------------|------|----------|
|                       |      |          |
|                       |      |          |
|                       |      |          |
|                       |      |          |
|                       |      |          |
|                       |      |          |

Your weight: \_\_\_\_\_ Kgs Your Height: \_\_\_\_\_ cm BMI: \_\_\_\_\_ (Hospital Use Only)  
(Essential for anaesthetic assessment)

**Do you have any special needs? If YES, please provide more details.**

**Yes No**

Disability \_\_\_\_\_  
  Physical support or aids \_\_\_\_\_  
  Religious or spiritual needs \_\_\_\_\_  
  Cultural or family/whanau needs \_\_\_\_\_  
  Dietary requirements: Standard  Diabetic  Vegetarian  Other  \_\_\_\_\_  
  Do you have anxieties, concerns, questions or additional matters you wish to discuss before your surgery with:  
Surgeon  Anaesthetist  Nurse  Administration   
  If your procedure requires the removal of any body parts, would you like them returned?

**Day Stay Patients**

**Yes No**

Do you have someone to drive you home?  
  Do you have access to a phone?  
  Do you have a support person to be with you 24 hours post surgery?  
How long does it take you to travel to your local hospital? \_\_\_\_\_  
Contact phone number on discharge: \_\_\_\_\_