REMUERA SURGICAL CARE
SURGICAL SPECIALISTS

Surgeon performing procedure:_____

PRE ADMISSION

To assist in making your admission process easier, please complete this form within 48 hours of receiving it. Once completed, mail it to Remuera Surgical Care using the envelope provided. If you have questions regarding this process, call (09) 522 5102.

Surname (family name)		❒ Mr ❒ Mrs ❒ Ms ❒ Miss ❒ Dr
First Name(s)		**Preferred Name**
Date of Birth		❒ Male ❒ Female
Country of Birth		Ethnicity
Residential Address		
Postal Address *(IF DIFFERENT FROM ABOVE)*		
Email		
Phone *HOME*	*WORK*	*MOBILE*
Occupation		

Have you ever been a patient at Remuera Surgical Care before?	Yes ❒	No ❒
Date of admission	Time of admission	Surgeon

PAYMENT

Payment is required on the day of surgery (the exception is full insurance cover)**.** Unpaid Accounts will incur late payment fees and collection costs. If you have Insurance Cover:

Insurance Provider	Policy Type:
Membership #	Prior Approval #
Is your surgery covered by ACC: Yes ❒ No ❒	ACC Approval granted: Yes ❒ No ❒
ACC Claim No	ACC Case Manager:

Method of payment: Eftpos ❒ Cash ❒ Cheque ❒ Credit Card ❒

☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ CCS Number: ☐☐☐ Expiry: ☐☐/☐☐

If you have Insurance Cover:

Insurance Provider	Membership #	Prior Approval #

Yes ❒ No ❒ Have you had any previous operations or admissions to hospital? If YES, where and what for?

SURGERY	DATE	HOSPITAL

Yes ❒ No ❒ Have you had any **allergies** or **sensitivities** to latex, iodine, medications, plasters, food, skin preparations or other substance? If YES, please list your allergies and describe the reaction:

_____

_____

YES ❒ NO ❒ Have you had a "head cold", throat or chest infection or bronchitis in the **past four weeks**?

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

YES ❒ NO ❒ Disability _____

YES ❒ NO ❒ Vision or hearing difficulties _____

YES ❒ NO ❒ Physical support or aids _____

YES ❒ NO ❒ Cultural, Spiritual or family/whanau needs _____

YES ❒ NO ❒ If your procedure requires the removal of any body part, and if possible, would you like them returned?

YES ❒ NO ❒ Dietary requirements: Standard ❒ Diabetic ❒ Vegetarian ❒ Food Intolerances ❒ Other: _____

YES ❒ NO ❒ Do you take street drugs or narcotics other than those prescribed for you?

YES ❒ NO ❒ Do you have any skin problems e.g. ulcers, bruises, wounds or dressings? If YES, please describe:

_____

Do you take any regular medications (including the contraceptive pill, inhalers, herbal remedies, eye-drops, sprays or regular over the counter medications e.g. aspirin)? YES ❒ NO ❒

MEDICATION	DOSE	FREQUENCY

YES ❒ NO ❒ Does anyone assist you with the administration of your own medication?

YES ❒ NO ❒ High blood pressure? If YES, is this being monitored by your GP? YES ❒ NO ❒

YES ❒ NO ❒ Are you, or could you be pregnant?

YES ❒ NO ❒ Have you or a blood relative ever had any problems with any anaesthetic? If YES, please describe:

_____

_____

_____

Do you currently suffer or have suffered any of the following?

YES ❒ NO ❒ Heart problems (angina, irregular pulse, fluid on lungs, pacemaker)

YES ❒ NO ❒ Rheumatic fever

YES ❒ NO ❒ Heart murmur

YES ❒ NO ❒ Asthma

YES ❒ NO ❒ Lung Problems (bronchitis, emphysema, TB)

YES ❒ NO ❒ Stroke

YES ❒ NO ❒ Diabetes

YES ❒ NO ❒ Epilepsy If yes, when was your last seizure

_____

YES ❒ NO ❒ Hepatitis, Yellow Jaundice or HIV

YES ❒ NO ❒ Blood clots to the legs or lungs

YES ❒ NO ❒ Blood disorder

YES ❒ NO ❒ Rheumatoid arthritis

YES ❒ NO ❒ Hiatus hernia, heartburn or acid reflux

YES ❒ NO ❒ Obstructive sleep apnoea (told you snore loudly then stop breathing)

YES ❒ NO ❒ Any other Medical Conditions (e.g. Alzheimer's, psychiatric history)?

_____

Who is going to care for you on discharge? _____

EMERGENCY CONTACT PERSON

Name		Gender: Male ❒ Female ❒
Relationship to you		
Residential Address		
Phone: *HOME*	*WORK*	*MOBILE*

FAMILY DOCTOR

Name:	
Address:	Phone: