



BRAEMAR HOSPITAL TO
AFFIX PATIENT DETAILS LABEL HERE

PRE-ADMISSION FORM BHL-PAF/04

As advised by your Surgeons rooms

Date of Admission: **Time of Admission:**

Nothing to eat from: Nothing to drink from:

Please choose from one of the following two options:

1. This form is a **fillable form** that can be completed online and saved as a PDF. You can type on the form and once completed save the form as a pdf, then email into us **admissions@braemarhospital.co.nz**; or
2. If you print the form to complete please then scan all pages, save as a PDF, and email to **admissions@braemarhospital.co.nz**. Please bring the original form with you on the day.

Legal Surname: Miss Ms Mrs Mr Dr

Legal First Names: Preferred Name:

Date of Birth: Country of Birth:

Female Male Are you a permanent NZ resident?: Yes No

Occupation: Religion: (optional)

Ethnicity:

Home Address

Postal Address
(If different to Home)

Home Phone: Mobile: Business:

Email: Email Invoice?: Yes No

Surgeon or Specialist:

GP's Name: Practice:

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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" accommodation for an adult with a child patient? Yes No

*Please bring ALL your current medications, toiletries and night wear to hospital with you.
Braemar Hospital is unable to accept any responsibility for loss or damage to valuables or money belonging to patients.*

HEALTH QUESTIONNAIRE TO BE COMPLETED BY THE PATIENT

FAMILY HISTORY HAS ANY OF YOUR BLOOD RELATIONS EVER HAD:

YES	NO	Bleeding or clotting disorders	YES	NO	Inherited muscular disorder
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PERSONAL HISTORY HAVE YOU EVER HAD OR DO YOU HAVE:

YES	NO	ALLERGIES or SENSITIVITIES			
		Have you ever had an allergic reaction or been sensitive to any drugs, iodine, sticking plaster, foods etc?			
		Sensitivity or Allergy <i>Drug/Medication/Substance</i>	Nature of Reaction <i>ie Rash/Swelling/Anaphylaxis/Diarrhoea</i>	Severity <i>Mild/Moderate/Severe</i>	

YES	NO	Anaemia	YES	NO	Heart attack/angina/chest pain
YES	NO	Any antibiotic resistant infection	YES	NO	Hepatitis A, B or C
YES	NO	Arthritis	YES	NO	High blood pressure
YES	NO	Asthma	YES	NO	HIV
YES	NO	Blackouts or severe headaches	YES	NO	Kidney disease
YES	NO	Bladder infections	YES	NO	Neuromuscular illness
YES	NO	Bleed or bruise easily	YES	NO	Rheumatic fever
YES	NO	Blood clots in the legs or lungs	YES	NO	Shortness of breath
YES	NO	Cough or bringing up sputum	YES	NO	Sight impairment
YES	NO	Convulsions or fits	YES	NO	Stroke
YES	NO	Diabetes	YES	NO	Swollen ankles
YES	NO	Epilepsy	YES	NO	Tuberculosis
YES	NO	Hearing difficulties	YES	NO	Unusual thumping or beating of the heart
YES	NO	Do you snore?	YES	NO	Do you stop breathing when you sleep and/or have sleep apnoea?
YES	NO	Other illnesses (please specify)	YES	NO	Problems with anaesthetics (please specify)
YES	NO	Previous surgery (please specify)			

YES	NO	Do you smoke?	How many cigarettes per day?
YES	NO	Do you drink alcohol?	How many alcoholic drinks per day?
YES	NO	Do you use recreational drugs?	What and how often?

YES	NO	Have you been in a hospital or health care facility overseas in the last 6 months?
YES	NO	Have you been in a hospital or health care facility in New Zealand where an outbreak of antibiotic resistant organisms (MRSA, ESBL etc) was reported?
YES	NO	Have you previously been found to be infected or colonised with MRSA?
YES	NO	Have you been in contact with measles, mumps or chicken pox in the last 2 weeks?

YES	NO	Do you have any physical, emotional, spiritual, cultural, dietary or communication needs that we need to know about? If yes, please specify.
YES	NO	Have you had any falls in the past 6 months
YES	NO	Females - is there a possibility you might be pregnant? (X-rays during surgery or anaesthetic drugs may cause harm to your baby) How many weeks / months? When was your last period?
YES	NO	Is there anything else we need to know about you or your medical history or individual needs that will help us to plan the best care for you? If so please specify.

