CONSENT: Form 1



Completing and Submitting your Admission Forms and Health Questionnaire

Attending an anaesthetic clinic?	Return Forms 2 and 4 to Royston Hospital no later than 10 working days prior to your procedure. Take Form 1 and Form 3 to your appointment, then return these forms to Royston Hospital.							
Not attending an anaesthetic clinic?	Return all four forms to Royston Hospital no later than 10 working days prior to your procedure: DELIVER/COURIER or POST Royston Hospital, 500 Southland Road, Hastings 4122 (envelope provided) or FAX (06) 873 1189 or EMAIL admissions@royston.co.nz If you faxed or emailed the forms to us, please bring the originals with you on admission.							
Admitting Specialist		Admissio	on Date					
Admission Time	Operation Date							
PATIENT DETAILS	(specialist to complete)							
			ADMISSION TYPE					
			DAY	/ SURGERY UN	JRGERY UNIT (DSU)			
				CASE (Ward E				
			ATIENT					
ODER ATION / DRO	CEDURE (specialist to complete	٥)						
OPERATION/PRO	CEDONE (specialist to complete	e)						
Diagnosis History of DVT/P	E/Anticoagulation Diabetic		Estimated ⁷	Theatre Time _	Mins			
CDECIAL DECLIER	E/Anticoagulation Diabetic	☐ ↑ BMI ☐ C	Disability [Other				
					on Page 2			
REQUEST FOR AN	EMENTS: Enter on Page 2 and ID CONSENT TO MEDICAL And after consultation with specialism.	nd complete C	learance A	ssessment o	on Page 3			
REQUEST FOR AN	EMENTS: Enter on Page 2 and ID CONSENT TO MEDICAL And after consultation with specialis	nd complete C AND SURGICAL st)	learance A	ssessment o	on Page 3			
REQUEST FOR AN (patient to complete I (patient or guardi agree that I have h	EMENTS: Enter on Page 2 and ID CONSENT TO MEDICAL At after consultation with specialist an of patient) ad an explanation to my satisfact	nd complete	learance A TREATME	ssessment o				
REQUEST FOR AN (patient to complete I (patient or guardi agree that I have h operation/procedur I consent to having	EMENTS: Enter on Page 2 and ID CONSENT TO MEDICAL A after consultation with specialism an of patient) and an explanation to my satisfacted/treatment on myself or my deblood tested for HIV / Hepatitis	nd complete C AND SURGICAL St) Protion of the intent pendant. B / Hepatitis C	learance A TREATME	SSESSMENT OF	of the			
REQUEST FOR AN (patient to complete I (patient or guardi agree that I have h operation/procedur I consent to having in the event of a st I understand and a	EMENTS: Enter on Page 2 and ID CONSENT TO MEDICAL A after consultation with specialist an of patient) and an explanation to my satisfact re/treatment on myself or my deblood tested for HIV / Hepatitis aff member or doctor is exposed gree that photographic images re	nd complete C AND SURGICAL st) Protion of the intent pendant. B / Hepatitis C to my blood may be made	learance A TREATME int Name t, risks and lil	int kely outcomes	of the			
REQUEST FOR AN (patient to complete I (patient or guardi agree that I have hoperation/procedur I consent to having in the event of a st I understand and a and stored confide I am aware that I m	EMENTS: Enter on Page 2 and ID CONSENT TO MEDICAL A after consultation with specialist an of patient) and an explanation to my satisfact re/treatment on myself or my de blood tested for HIV / Hepatitis aff member or doctor is exposed gree that photographic images rentially as part of my health recornary ask for more information above.	nd complete C AND SURGICAL st) Pr tion of the intent pendant. B / Hepatitis C to my blood may be made rd for this episode out treatment at a	learance A TREATME int Name t, risks and lile e of care any time.	int kely outcomes Yes	of the			
REQUEST FOR AN (patient to complete I) (patient or guardi agree that I have hoperation/procedure I) consent to having in the event of a still understand and a and stored confider I am aware that I means to complete I aware that I means to comp	EMENTS: Enter on Page 2 and ID CONSENT TO MEDICAL A after consultation with specialist an of patient) and an explanation to my satisfact re/treatment on myself or my developed tested for HIV / Hepatitists aff member or doctor is exposed gree that photographic images rentially as part of my health recording ask for more information about the specialist and ask that the	nd complete C AND SURGICAL st) Pr tion of the intent pendant. B / Hepatitis C to my blood may be made rd for this episode out treatment at a	learance A TREATME int Name t, risks and lile e of care any time. t be carried of	essessment of the second of th	of the			

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Admitting Specialist		Admission	n Date				
Admission Time	Admission Time						
PATIENT DETAILS	(specialist to complete)						
		ADMI	MISSION TYPE				
			D	DAY SURGERY UNIT (DSU)			
			D	AY CASE (Ward Bed)			
	NHI No.		IN	NPATIENT N	GHTS		
OPERATION/PRO	CEDURE (specialist to complete)						
Operative side of b	oody: Left / Right / Bilateral / N/A (olease circle)					
			Estimate	d Theatre Time	Mins		
Diagnosis							
☐ History of DVT/P	E/Anticoagulation Diabetic ^	BMI Di	isability	Other			
SPECIAL REQUIRI	EMENTS:						

Affix Patient Label, or provide
Patient Name/DOR/Address/NHLNo

INPATIENT CLEARANCE ASSESSMENT (specialist to complete)

		(-)							
MRSA				ESBL					
Yes / No	Resident in a rest-home or long term care facility, excluding independent units?			Yes / No Admitted to an Overseas hospital in t last 6 months?					
Yes / No	Clinically employed in a hospital or rest home in the last 6 months?			Yes / No Treated in a health facility in Pakistan or Indian sub-continent in the last 6 months					
Yes / No	Admitted to a hospital in NZ or Overseas for more than 24 hours and has had surgery or an invasive procedure			Yes / No Indwelling catheter in-situ for >2 weeks? Yes / No Previous history of ESBL colonisation or					
Yes / No	(eg PICC line insertion) in the last 6 months?Previous history of MRSA colonisation or infection?			infection? If YES to one or more criteria swab patient. Day Surgery patients are excluded.					
	ne or more criteria : y patients are exclu								
REQUEST I	FOR AND CONS	ENT TO ANAES	THESIA (oatient to sigr	n after bein	g asse	essed by anaes	thetist)	
	II. 6 41								
	or guardian of patie			Name	6		e had explaine		
anaesthetic	requirements assoc	iated with the pro	cedure(s) as	listed overlea	f including t	he ini	nerent benefits	and risks of:	
G	eneral Anaesthesia		Epidural /	Spinal Anaes	thesia		Local Anaesth	esia	
Ir	Intravenous Sedation			Regional Nerve Block					
I accept the	e recommendation	of Dr					regarding the	ese options.	
Patient / G	uardian								
Anaesthetic Specialist									
Signature									
CONSENT	FOR BLOOD PRO	DDUCTS (patien	t to comple	ete after consu	ultation wit	h adr	nitting speciali	st)	
Consent gi	ven to receiving								
Consent no	ot given to receiving	g							
	n provided with the answered to my sa		d all my que	estions			Yes	No	
Patient / G	uardian								
in relation	vho has explained i to the administrati	on of							
blood com	ponents / blood pro	oducts							

A copy of the directive is attached

ADVANCE DIRECTIVE (patient / guardian to complete if required)