PLEASE RETURN THIS FORM **AT LEAST ONE WEEK** PRIOR TO YOUR OPERATION/PROCEDURE DATE

PATIENT REGISTRATION FORM
HE PUKA RĒHITA TŪRORO

Kākāriki Hospital

YOUR DETAILS (to be completed by patient)

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr Other: _____ Gender: _____

Legal First Name(s): _____ Date of Birth: / /

Family Name: _____ Marital Status: _____

Previous Name: _____ Occupation: _____

County of Birth: _____ NZ Resident: Yes ☐ No ☐ NHI No: *(If known)* _____

Residential Address: _____

Postal Address (If different from above): _____

Phone: Home ( ) _____ Work ( ) _____ Mobile ( ) _____

Email: _____

Ethnic Group: _____ Language Spoken: _____ Interpreter Required: Yes ☐ No ☐

Interpreter services must be arranged through your specialist's rooms prior to admission

If visiting from overseas what is your address while staying in New Zealand?

_____ Phone: ( ) _____

EMERGENCY CONTACT PERSON

Name: _____ Gender: _____

Relationship to Patient: _____

Residential Address: _____

Phone: Home ( ) _____ Work ( ) _____ Mobile ( ) _____

HEALTH INSURER

Name of Insurer: _____ Policy Type: _____

Membership No: _____ Prior Approval No: _____

Is your surgery covered by ACC: Yes ☐ No ☐ ACC Approval Granted: Yes ☐ No ☐

ACC Claim No: _____ ACC Office: _____ ACC Case Manager: _____

GENERAL PRACTITIONER

Name: _____

Practice: _____

REFERRING MEDICAL PRACTITIONER (If different from GP)

Name: _____

Practice: _____

Name: _____ Date of Admission: / / Time of Admission: _____

☐ High Use Health Card Expiry Date: /

☐ Prescription Subsidy Card Expiry Date: /

☐ Community Services Card Expiry Date: /

☐ Other Expiry Date: /

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ACC CLAIMS

Contract Claim:

If your medical operation/procedure is an ACC Contract Claim, ACC will pay the hospital directly for all hospital and specialist's costs excluding personal expenses. Personal expenses, such as visitor meals, will be invoiced directly to patients post-discharge.

Part ACC/Part Insurance:

Proof of prior approval is required prior or on admission for the portion of your procedure that is covered by insurance. If you are not insured, you will be required to pay a portion of the estimated hospital costs prior or on admission. For further details on ACC reimbursement practices please ask your ACC case manager.

PAYMENT OF HOSPITAL COSTS

For further information please refer to the Patient Information Booklet.

Payment will be made by: ☐ credit card ☐ internet banking ☐ EFTPOS ☐ cash ☐ other*

- If you have no insurance you will be required to pay the full estimated cost of the operation/procedure **on or before admission**
- If internet banking is done within 3 days prior to your admission, you may need to provide proof of the transaction prior to admission
- We strongly recommend you contact our bookings team 09 892 2902 for an estimate of the hospital costs prior to admission
- If you have prior approval with a private health insurer, you will need to pay any expected shortfall on or before admission
- You understand and give consent that relevant information may be supplied to an external credit reporting agency to obtain a credit report
- You agree you are responsible and will pay for all costs incurred in connection with your treatment
- You understand that Kākāriki Hospital may notify a credit reporting agency and/or instruct a debt collection agency should you default on any payment due by you to Kākāriki Hospital
- You understand that any collection and/or legal costs incurred in recovering any debt will be charged to you

PERSONAL PROPERTY

- You understand and agree that Kākāriki Hospital is not and will not be responsible for loss of or damage to any personal property (including jewellery, dentures, watches, rings, glasses) which you may bring into the hospital
- You consent to Kākāriki Hospital sharing relevant information that is related to your healthcare and as required by third parties such as Health Insurers, Medical Specialists, ACC, and for quality and audit purposes

To the best of your knowledge the information you have supplied to Kākāriki Hospital is correct.

Signature:

Print Name (in full):

Date: / /

PLEASE RETURN THIS FORM **AT LEAST ONE WEEK** PRIOR TO YOUR OPERATION/PROCEDURE DATE
You can email this form to bookings@kakarikihospital.co.nz

PLEASE RETURN THIS FORM **AT LEAST ONE WEEK** PRIOR TO YOUR OPERATION/PROCEDURE DATE

PATIENT REGISTRATION FORM
HE PUKA RĒHITA TŪRORO

Kākāriki Hospital

Dear Patient

The information requested in this form will help us assess your needs and plan your care for your booked admission to Kākāriki Hospital. All information will be treated in strict confidence.

When answering the questions, please do not write 'see my notes' or words to the same effect because we will not have all your clinical notes. Please answer as accurately as possible.

Please answer **all questions** on each page even if you think they are irrelevant to your circumstances.

Please bring any relevant x-rays / CT / MRI scans (CD discs) with you along with any mobility aids, CPAP machines etc. to the hospital. If you develop any coughs, colds, infections or wounds before your admission, contact your specialist prior to your admission.

Please ensure you are aware of when you should stop eating and drinking prior to your admission. Your specialist should advise you of these times. Please note this includes chewing gum, lollies, sugar etc. If you do not follow these instructions you risk having your surgery cancelled.

We look forward to helping you prepare for your operation.

Admissions Unit Nurses

YOUR DETAILS

Legal Name: Date of Birth: / /

Planned Procedure:

Date of Surgery: / / Best Contact Phone Number: ( )

FOR HOSPITAL USE ONLY

Pre-Admission Review: ☐ Reviewed; no further action required ☐ Reviewed; patient contacted

Action Taken:

Date unable to contact (1st Attempt): / /

Date unable to contact (2nd Attempt): / /

Name: Designation:

Signature: Date: / /

To be filed in the Clinical Record