

Admission Form

Important!

Email your completed forms to reception@wakefield.co.nz

Alternatively you can drop them off at reception several days before admission.

Admitting practitioner:

Personal Details (patient to complete)

Admission date:

Personal details:

Preferred Name	<small>First name</small>	<small>Middle name</small>	<small>Surname</small>	Date of birth	Age	NHI No:
Gender	<small>Known as</small>					<small>If known</small>
	Male <small>Tāne</small>	Female <small>Wahine</small>	Another <small>He ira kē anō</small>		Are you: NZ Citizen	Permanent resident
Ethnicity	Māori	New Zealand European	Samoan	Cook Island Māori	Tongan	
	Niuean	Chinese	Indian	other		<small>such as Dutch, Japanese, Tokelauan. Please state</small>
Email						
Telephone	<small>Home</small>	<small>Work</small>	<small>Mobile</small>			

Address:

Postcode

Billing Address:

Postcode

GP Information:

Medical Centre
or Clinic

GP's name

Prefer not to say

Contact person during stay:

Mr/Ms/Mrs/Miss/Dr

Relationship to
patient

Address

Telephone

Home

Work

Mobile

How best to contact you:

How to contact you

When is the best time for you
to receive calls from our staff?

Are you happy for us to leave a message on an
answer phone?

Yes

No

Are you happy for us to leave a message with a person?

Yes

No

If so, who?

Dietary needs:

The preassessment nurse will ask you for more information on any dietary requirements you may have.

Please indicate any dietary requirements:

Gluten free Dairy free Lactose free Pescatarian Vegetarian Vegan Keto
FODMAP Other
Allergies/intolerances

Payment and Insurance Details (patient to complete)

Please tick the relevant box for the funder of your procedure and complete all relevant section(s). If you do not know the information, please submit your forms and a representative from our hospital will be in touch.

ACC (Accident Compensation Corporation) Medical insurance Other Paying personally

ACC

Claim number: *(If unknown, our staff will be happy to chase this information.)*

Medical Insurance

Name of insurer:

Have you obtained prior approval for payment? Yes No **If yes,** Approval number:

If no: If you are uninsured and this procedure is not covered by any other funders, then you agree to prepay an account estimation supplied by the hospital.

Other Health New Zealand Contract

Details:

Paying Personally

If you are uninsured and this procedure is not covered by any other funders, then you agree to prepay an account estimation supplied by the hospital prior to admission. Please sign and complete the payment agreement below.

The hospital will send you a letter detailing how you can make payment via a debit card, credit card or bank transfer.

Agreement (patient to complete and sign prior to admission)

1. I understand that if I do not have full cover medical insurance or prior approval from my insurer, I agree to pay a co-payment/estimated amount prior to admission. This will be provided to me by the Hospital on request.
2. I understand that some costs such as laboratory testing, transfer and/or ambulance costs and other specialist costs such as radiology and occupational therapy will be billed separately and may be payable by me.
3. I understand that the admitting practitioner and anaesthetist using the Hospital facilities are independent practitioners who are not employees of the Hospital. I understand I have a direct relationship with them in respect to treatment care and payment of their accounts.
4. I understand and agree that Wakefield Hospital may need to collect information about me from, and disclose my information to, my insurance provider or other treatment funders as required to assess my funding claim and/or for funding pre-approval.
5. The Hospital reserves the right to add collection costs and interest as per its terms of trade.
6. I understand and agree that Wakefield Hospital, its medical specialists and other health professions, may need to access and collect my health and other personal information from both myself and others (including my GP, referring doctor, the public hospital system, other health professionals and organisations involved in my care, my insurance provider, and my whānau members), to ensure that I receive appropriate medical care, and that, where necessary for my care, my information may also be disclosed to those groups. I understand that the details of how Evolution collects, uses and discloses my personal information are set out in Evolution's privacy statement available here: wakefield.co.nz/privacy-statement
7. I understand that other clinical team members such as student nurses and qualified medical trainees may have supervised involvement with my care and that I have a right to decline their presence or contribution to my care delivery.

Please sign your name in the signature box to indicate your approval of the information provided. We will also verify this information with you in person on the day of admission.

Signature:

Date: