IntraCare

Patient Registration Pack

Welcome to IntraCare

At IntraCare, our commitment is to ensure an outstanding experience for our patients. We prioritise delivering the highest quality care with compassion and respect. We understand that navigating healthcare can be challenging, and we strive to make your experience as comfortable as possible. This registration pack is designed to gather essential information, so we can provide the best and safest care tailored to your needs. Remember, you are not alone; every member of our team is dedicated to assisting you and your whānau in your healthcare journey.

Everything Matters.
Everyone Matters.
Every Moment Matters

Inside this booklet

You'll find the patient registration form and patient health questionnaire in this booklet. Further information about your admission, stay with us, recovery and your discharge can be found in the booking email attachments.

You will also be contacted by a nurse 48 hours prior to your procedure to discuss any remaining questions you may have.

Checklist

- ☐ Complete the Patient Registration Form (pg 4-7)
- ☐ If you are paying for your procedure or have an insurance excess, payment is required at least one business day prior to your admission (pg 5)
- ☐ Provide a copy of the prior approval letter from your insurance company, at least one business day prior to your admission
- ☐ Complete the Health Questionnaire (pg 9-13)
- ☐ Please ensure you are aware of when you should stop eating and drinking prior to your admission. If you do not follow these instructions, you may risk having your procedure rescheduled
- ☐ Bring any mobility aids you may require with you
- ☐ Arrange transport to and from the hospital
- ☐ Send your completed forms to IntraCare
  - ○ We must receive your forms at least 3 days prior to your admission so that we can confirm your booking
  - ○ Please save your completed forms and send them in an e-mail to admin@intracare.co.nz

---

If you develop any coughs, colds, infections or wounds before your admission, please contact IntraCare.

Patient registration form

Please return this completed form at least 3 days prior to your admission.

Your details *(to be completed by patient)*

Title: _____ Legal first name(s): _____

Surname: _____ Preferred name: _____

Gender: _____ Date of birth: _____/____/_____

NZ resident: ☐ Yes ☐ No NHI no. (if known): _____

Residential address: _____

_____

Postal address (if different from above): _____

_____

If visiting from overseas, what is your address and phone number whilst staying in NZ?

_____

Phone: Mobile: _____ Home: _____ Work: _____

Email: _____

Language spoken: _____ Interpreter required: ☐ Yes ☐ No

(IntraCare will organise an interpreter prior to your admission if required. This service will be free of charge.)

Which ethnic group do you belong to? Select the group or groups that apply to you.

☐ New Zealand European ☐ Māori ☐ Samoan

☐ Cook Island Māori ☐ Tongan ☐ Niuean

☐ Chinese ☐ Indian

☐ Other (such as Dutch, Japanese, Tokelauan). Please state _____

Emergency contact person

Name: _____ Relationship to patient: _____

Phone: Mobile: _____ Home: _____ Work: _____

Health insurer

Name of insurer: _____ Policy type: _____

Membership number: _____ Prior approval number: _____

Family doctor

Name: _____

Practice: _____ Phone: _____

Personal property

You understand and agree that IntraCare is not and will not be responsible for the loss of, or damage to, any personal property (including jewellery, dentures, watches, rings, glasses) which you may bring.

Payment terms

- The price shall be as indicated on the invoice(s) provided by IntraCare to you in respect of the Services supplied. Unless otherwise stated, all prices include GST.
- For insurance funded procedures, IntraCare requires a copy of the prior approval letter. If we do not receive the prior approval letter at least one business day prior to your admission, you will need to pay for the procedure and claim this back from your insurer.
- IntraCare is affiliated with Southern Cross and AIA, IntraCare can claim the cost of some procedures from these affiliated providers. If you are unsure whether your procedure is covered, please contact our administration team on (09) 630 1961.
- If you are not fully insured and/or have an excess or co-payment, you will need to pay the portion not covered by insurance and/or the excess, at least one business day prior to your admission. If payment is not received within this time frame, your procedure booking date may be rescheduled. Please contact our administration team to arrange payment.
- Any amounts due to IntraCare relating to your procedure either from you, your insurance provider or other party remains your full responsibility, however arising, including overdue payment, nonpayment, outstanding part-payment or if your insurance provider or other party subsequently declines cover or part cover.
- If you have an outstanding balance due to IntraCare, you agree to indemnify IntraCare from and against all costs and disbursements incurred by IntraCare in recovering the debt (including but not limited to internal administration fees, legal costs, IntraCare's collection agency costs and bank dishonour fees).
- The actual cost of the procedure may vary to the estimate. If you are not fully insured and/or have an excess or portion to pay, you may be invoiced for an additional amount if the actual cost of your procedure is higher than the estimate. This is payable upon invoice. If the cost of the procedure is lower than the estimate, you may be eligible for a refund for any overpayment. Refunds are typically paid within 7 business days.

Please provide your bank account name and bank account number so that refunds can be processed promptly.

Bank account name: _____

Bank account number: _____

Privacy and financial interests disclosure statement

For the purposes of this Privacy and Financial Interests Disclosure Statement, "IntraCare" is an agency, and means:

1. The Company, Intra Limited, employees including technical staff, nursing staff and administrative staff; and,
2. Medical Specialists credentialed to work with IntraCare.

IntraCare understands the privacy of your personal and health information is important to you. In this Statement we use the term "Personal Information" to include both personal and health information, and we explain how we meet our obligations under the Privacy Act 2020; Health Information Privacy Code 2020 and other relevant legislation when we collect, use and share your Personal Information.

Collection of your Personal Information:

IntraCare usually collects Personal Information directly from you. We also collect information about you from the doctor or agency that referred you to IntraCare. Where necessary to ensure we can provide you with safe and effective services we may also collect Personal Information about you from other persons such as your General Practitioner, specialist, any other health professional who has treated you for a relevant condition, your family or whānau with your consent, or other sources if you consent or we are authorised by law.

Purposes for which we use your Personal Information:

We collect and use information about you to ensure we can provide high quality, safe and effective services to you. This may include, but is not limited to: the provision of medical care and advice; making appropriate referrals to other health professionals; monitoring the quality of, and improving, our services; providing relevant training to our staff and health professionals providing services at IntraCare; responding to enquiries, concerns or complaints; and for matters related to the administration of those services including charging, billing, and debt collection. We also securely share limited personal data with Cemplicity for the sole purpose of facilitating a patient feedback survey invitation to you. The data shared with Cemplicity will not be held longer than the purpose of conducting the patient's survey i.e. 21 days. All data stored by Cemplicity is to ISO 27001 standard and in accordance with the Privacy Act 2020.

Access and correction of your Personal Information:

You have a right to seek access to and correction of Personal Information we hold about you in accordance with the Privacy Act 2020 and Health Information Privacy Code 2020. To ensure the security of your information, we will ask you to verify your personal details, before we release any information to you.

Possible financial interest in the facility or part of the facility:

The doctor you see may have a financial interest in part of the facility in which you receive treatment or may be referred to, but at all times has a duty to act in your best interests when making referrals and providing or arranging treatment or care. If you have any questions about this please ask the doctor concerned.

IntraCare is the agency collecting your Personal Information and holding that information. Our office address is 98 Mountain Rd, Epsom, Auckland. If you have any questions relating to how your personal information is collected, used or may be disclosed please contact our Privacy Officer at: admin@intracare.co.nz or (09) 630 1961.

Intended recipients and disclosure of your personal information:

When you receive treatment or procedures at IntraCare, a procedure report is provided to your referring health professional. We may also disclose relevant Personal Information connected to the provision of your medical care and/or the services provided to you by IntraCare, to: your General Practitioner; other health professionals or health service providers involved in your treatment or diagnostic services or where we make referrals on your behalf; or to Health New Zealand and/or ACC where relevant. We provide relevant information to Testsafe, a secure electronic database provided by Health New Zealand. This enables health providers who are involved in providing care to you to access relevant clinical information to improve services to you, especially in the event of a complication or emergency. Only authorised health providers have access to this system. We may also disclose relevant Personal Information about you where it is necessary to submit health insurance claims on your behalf; for quality assurance, audit and accreditation issues; or where the disclosure is otherwise authorised or required by law.

Providing Personal Information and signing this Statement:

You do not have to provide Personal Information to IntraCare, however not providing Personal Information may impact on our ability to provide you with the services you require. By ticking that you consent, and signing this Privacy and Financial Interests Disclosure Statement, you consent that your Personal Information may be collected, used and disclosed as explained above. If you do not consent to the possible disclosure of your information to a third party outside of IntraCare as set out above, please tick the "do not consent" box, and we will request your consent in relation to any specific disclosure that is proposed, unless the disclosure is authorised or required by law.

Signature

I understand my Personal Information will be collected and used for my treatment or procedure.

Please tick one:

☐ **I consent** to my Personal information being shared as explained in the paragraph 'Intended recipients and disclosure of your personal information'

OR

☐ **I do not consent** to my Personal information being shared as explained in the paragraph 'Intended recipients and disclosure of your personal information'

I understand that the doctor I see may have a financial interest in part of the facility but is required at all times to act in my best interests. I have had an opportunity to ask any questions about this and understand I can discuss any concerns I have about this at any time.

Signature _____

Print name (in full) _____ Date _____

Sample Consent form

Consent for Procedure

IntraCare

Patient Label

Patient name: _____

Date of birth: _____ NHI: _____

Interpreter *(Fill out only if needed)*

◯ **Yes I do** ◯ **No I do not** — want an interpreter

Interpreter name: _____

Language: _____

Planned procedure

_____

_____

Summary of information given

This may include a description of the procedure discussion of risks and benefits, potential complications, alternatives to treatment, decisions that may need to be made during the operation, procedures the patient does **not** want done. Please reference clinic letters and patient information sheets where applicable.

Potential complications include: _____

_____

_____

_____

Staff exposure to blood or body fluids

If a staff member sustains accidental exposure to my blood or body fluids, a blood sample may need to be taken for blood-borne diseases including HIV, Hepatitis B, and Hepatitis C. I consent for the collection of a blood sample in the event of staff injury or exposure. I understand that I will be informed of the results of the blood tests and treatment options if a disease is detected.

Blood or blood products transfusions *(Fill out only if needed)*

Blood or blood product transfusion may be needed during or after the procedure. The reasons for transfusion, the alternatives, and the possible risks have been discussed with me. I have been provided with the **NZ Blood Service Fresh Blood Components** information.

◯ **I agree** to the administration of blood or blood products as considered necessary and medically appropriate, including if my life is in danger. I understand I can withdraw this consent at any time.

◯ **I do not agree** to the administration of blood or blood products under any circumstances, even if my life is in danger. I understand I can alter my decision at any time.

Information received and consent given

- I have had explained to me the nature of my / the patient's condition, the procedure and options for treatment.
- I have been given the opportunity to include my whānau/support persons in my discussions, where this is important to me.
- I have been provided with an assessment of the potential benefits, common or significant side effects and likely outcome of the procedure.
- I have had explained to me situations that may arise during the procedure and possible complications.
- I have had adequate opportunity to ask questions and I am satisfied with the explanation and the answers to my questions.
- I have had the opportunity to state any procedures **I do not** want performed.
- I consent for the collection of a blood sample in the event of a staff "needle stick injury" or other blood accident/exposure.
- I consent to the administration of Section 29 drugs if they are required, and I consent to my personal information being given to Medsafe if Section 29 drugs are administered.

I, or my legal representative, consent to the procedure/s described in this consent form above to be performed on myself:

Patient/Legal representative name: _____ If not patient, state _____

relationship to patient: _____

Signature: _____ Date: _____

Clinician name: _____ Designation: _____

Clinician signature: _____ Date: _____

Legal representative

- "Legal representative" means welfare guardian, enduring power of attorney (care and welfare), or guardian of a child.
- Next of kin does not have legal authority to consent on behalf of an incompetent patient however they may be consulted.

CON 0725

Health questionnaire

Dear Patient,

The information requested in this form will help us assess your needs and plan your care for your admission to IntraCare.

Please answer **all questions** on each page as accurately as possible.

We may not have all your previous medical records, please do not write "see my notes" or words to that effect.

You will be contacted by a nurse 48 hours prior to your procedure to discuss your admission, recovery and discharge information.

Do you have, or have you ever had any of the following:

High blood pressure controlled with medication	☐ Yes	☐ No
Heart attack	☐ Yes	☐ No
Heart murmurs	☐ Yes	☐ No
Heart valve disease	☐ Yes	☐ No
Chest pains/angina	☐ Yes	☐ No
Coronary stents	☐ Yes	☐ No
Rheumatic fever	☐ Yes	☐ No
AF/palpitations/arrythmias	☐ Yes	☐ No
Cardiac devices e.g. pacemaker, ICD	☐ Yes	☐ No
High cholesterol	☐ Yes	☐ No
Ischemic heart disease	☐ Yes	☐ No
COPD/emphysema	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Have you had a 'head cold', throat/chest infection or bronchitis in last 4 weeks	☐ Yes	☐ No
Persistent cough	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No
Obstructive sleep apnoea	☐ Yes	☐ No
Stroke/TIA	☐ Yes	☐ No
Anaemia/bleeding disorders	☐ Yes	☐ No
Blood clots in legs or lungs (DVT/PE)	☐ Yes	☐ No

Epilepsy/seizure	☐ Yes	☐ No
Blackouts/fainting	☐ Yes	☐ No
Heartburn/reflux	☐ Yes	☐ No
Diabetes: Type 1	☐ Yes	☐ No
Type 2	☐ Yes	☐ No
Kidney problems	☐ Yes	☐ No
Hepatitis A/B/C	☐ Yes	☐ No
Cirrhosis	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Mental illness	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Dementia/Alzheimer's	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Joint implants or metalware	☐ Yes	☐ No
Do you use:		
Crutches, walking stick	☐ Yes	☐ No
Walking frame	☐ Yes	☐ No
Wheelchair	☐ Yes	☐ No
Have you had a fall in the last 6 months?	☐ Yes	☐ No
Is your activity currently restricted by pain?	☐ Yes	☐ No
Bowel conditions	☐ Yes	☐ No

Do you have, or have you ever had any of the following: (continued)

Bladder conditions	☐ Yes	☐ No
Have you suffered post-op nausea and vomiting with recent surgeries?	☐ Yes	☐ No
Have you or a blood relative ever had any problems during or after anaesthesia? e.g. Malignant Hyperthermia, muscular dystrophy	☐ Yes	☐ No
Have you ever been told by a doctor you had a difficult airway?	☐ Yes	☐ No
Do you wear dentures?	☐ Yes	☐ No
Problems opening your mouth?	☐ Yes	☐ No
Are you or could you be pregnant?	☐ Yes	☐ No

Current skin problems e.g. ulcers, wounds, eczema, boils	☐ Yes	☐ No
Have you ever smoked?	☐ Yes	☐ No
☐ Less 10/day ☐ 11-19/day ☐ 20+ a day		
☐ Never Quit date: _____		
Do you drink alcohol?	☐ Yes	☐ No
If yes, how many units weekly? *(1 standard glass of wine or ½ glass of beer = 1 unit)*		
☐ >10 ☐ 5-10 ☐ <5		
Do you use recreational drugs?	☐ Yes	☐ No
Wear glasses/contact lenses	☐ Yes	☐ No
Other eye conditions	☐ Yes	☐ No
Hearing difficulties	☐ Yes	☐ No

Special dietary requirements:

_____

_____

_____

If you answered yes to any of the above, please give details:

_____

_____

_____

Do you have any planned surgeries within the next 3 months? ☐ Yes ☐ No

Please specify: _____

Do you have other medical conditions not covered by the health questionnaire? ☐ Yes ☐ No

Please specify: _____

Are you under medical specialist care, cardiologist, oncologist, rheumatologist? ☐ Yes ☐ No

Please specify: _____

Do you have religious beliefs/practices or cultural needs we can support you with? ☐ Yes ☐ No

Please specify: _____

Have you ever had MRSA, ESBL, VRE or CRE? ☐ Yes ☐ No If Yes, date: _____

Health questionnaire (continued)

Have you lived or travelled overseas in the last 12 months? ☐ Yes ☐ No

Please specify: _____

Have you worked in a healthcare facility in the last 12 months with hands-on patient care? ☐ Yes ☐ No

Please specify: _____

Have you been a patient in ANY hospital in the last 12 months? ☐ Yes ☐ No

Hospital: _____ *No. of nights:* _____

This information is important, if you are unsure of your height or weight, the nurses at IntraCare will obtain this on your admission.

Height: _____ *Weight:* _____

Are you allergic/sensitive to any medications/foods/latex/plasters/tape/Xray contrast dye/skin preparation e.g. iodine

Substance	*Reaction*

List all previous admissions to hospital for surgical procedures

Previous surgery	*Hospital*	*Year*

Health questionnaire (continued)

List ALL medicines – tablets, inhalers, patches; prescribed by your doctor or over the counter

Name of medications	*Dose*	*Frequency*

Does anyone assist you with administration of your own medication?

Please specify: _____

Please bring all your medications, in original packaging, with you to the hospital.

Discharge planning

Please make arrangements for your discharge, including if you require someone to stay with you overnight. This information will be discussed during your pre-admission phone call with an IntraCare nurse.

Carer support

Who will be caring for you on discharge?

Name: _____ Relationship to patient: _____

What are your current living arrangements?

☐ Live alone

☐ Live with others i.e. partner/children.

Please specify: _____

Discharge/transport

You may be unable to drive after your procedure, due to sedation. Therefore it is important that you organise someone to collect you on discharge.

Name: _____ Relationship to patient: _____

Contact phone number: _____

Comments: _____

_____

_____

To the best of your knowledge the information you have supplied above to IntraCare is correct. It is important to know who has completed the Health Questionnaire. Please print and sign your name.

Print name (in full): _____ Date: _____

Signature: _____ Relationship to patient: _____

If you are completing the form on behalf of someone else, please specify your relationship to the patient.

Please return this completed form at least 3 days prior to your admission.

IntraCare

Intra Limited
E: admin@intracare.co.nz
W: intracare.co.nz
P: +64 9 630 1961 (Monday to Friday 6:30am–6:00pm)
P: +64 27 482 0763 (after hours, weekends and public holidays)