

HOSPITAL BOOKING LETTER

MRN ACN.....

Surname

Given Names

D.O.B

AMO Name please print

.....

Doctor to complete this form

PERF & PUNCH POSITIONING AS PER PREVIOUS BOOKLETS

HOSPITAL BOOKING LETTER

MR 1ABS

Patient Details	Title	Surname	Given Name (s)
Date of birth	Unit / Street No./ Street Address		Home Ph
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Suburb	P/Code	Mobile Ph
Clinical Details	Provisional Diagnosis		
Diabetes	<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Type 2 on insulin		Diabetic instructions (if applicable)
* VTE Prophylaxis	Chemical <input type="checkbox"/> Yes <input type="checkbox"/> No Mechanical <input type="checkbox"/> Stockings <input type="checkbox"/> SCD <input type="checkbox"/> No If No, state reason.....		Co-morbidites (leave blank if 'No')
Confirmed MRO	(MRSA, VRE, ESBL, MRAb) <input type="checkbox"/> Yes <input type="checkbox"/> No		
Latex allergy	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Weight	NB patients > 140kg cannot be admitted: <input type="checkbox"/> < 110 kg <input type="checkbox"/> 110-140 kg <input type="checkbox"/> Weight > 140kg		
Other allergies	Other known infectious risk		
Admission Details	Admission date <input type="checkbox"/> Overnight expected # Overnight booking confirmed		<input type="checkbox"/> GA <input type="checkbox"/> ALA <input type="checkbox"/> LA <input type="checkbox"/> Topical
	Pre-admission by: <input type="checkbox"/> SDSH PAC <input type="checkbox"/> AMO <input type="checkbox"/> diagnostic results following		
Procedure Details	Operation /Procedure Date		CMBS Item No.(s)
Planned Procedure(s)			
Equipment Details	Implantable device <input type="checkbox"/> Implanting Device <input type="checkbox"/> Removing device	Type Company <input type="checkbox"/> Contacted	Type Company <input type="checkbox"/> Contacted
Will the prosthesis used attract a gap payment? <input type="checkbox"/> No <input type="checkbox"/> Yes If so, gap estimate \$.....		Has informed financial consent been provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	Patient Signature
Pre-operative consultation		Other instruction notes	
Anaesthetist			
Pre-operative tests	Please organise the following tests <input type="checkbox"/> ECG <input type="checkbox"/> Other		
Required test (s)			
Could this patient be pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Specific medication orders at admission (see over)	
<input type="checkbox"/> Consent to Medical / Surgical Treatment completed			
AMO Signature			
Date/...../.....			

Doctor / Secretary only:
FOR ALL ADMISSIONS
Please fax this side to 94762921

Doctor / Secretary only:
Please fax this & copy of consent form
Photocopy for your records and hand
originals to patient



