

Date of Admission:
Date of Surgery:

PRE – ADMISSION CLINICAL REFERRAL

TO BE COMPLETED BY THE MEDICAL OFFICER

Surname: _____ First Name: _____ D.O.B: _____

Attending Medical Officer: _____

Provisional Diagnosis: _____

Proposed Operation/Treatment: _____

Explained to patient and consent complete: Estimated Operating Time: ____ Hours ____ Minutes

LENGTH OF STAY: Please note all patients will be admitted on the **day of their procedure** unless a suitable reason is provided.

Admit ____ day/s prior to procedure. **Reason:** _____

DAY ONLY SURGERY _____

1 NIGHT (Extended Day Only 23 hours) _____

> 1 NIGHT Est. Length of Stay ____ Nights _____

ANAESTHETIC INFO:

- | | |
|--|---|
| <input type="checkbox"/> Suitable for Local Anaesthesia | <input type="checkbox"/> HDU Bed required |
| <input type="checkbox"/> Cease Aspirin _____ Days Preop | <input type="checkbox"/> Cease Clopidogrel _____ Days Preop |
| <input type="checkbox"/> Anticoagulant Medication _____ Cease _____ Days Preop | |
| <input type="checkbox"/> Diabetic Medication _____ Cease _____ Days Preop | |

This patient requires a pre-operative anaesthetic consult Yes No

ALLERGIES (Drugs, Latex, Dressings):

CO-MORBIDITIES:	CURRENT MEDICATIONS

INVESTIGATIONS REQUIRED (apart from routine Preop guidelines):

OTHER PREOP INSTRUCTIONS / TREATMENT ON ADMISSION / EQUIPMENT REQUIRED:

Name: (Please Print) _____ Designation: _____

Signature: _____ Date: _____

BINDING MARGIN - DO NOT WRITE