246 Clayton Road, Clayton Vic 3168 Tel 9594 2776

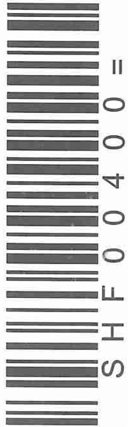
Unit Record Number ....

Surname ....

Given Name ....

D.O.B. .... Age .... Sex ....

Affix Patient Identification Label



DOCTOR TO COMPLETE PATIENT BOOKING FORM A

Consultant: .... Contact Number: ....

Patient Surname: .... Given Name: ....

Date of Birth: .... ☐ Male ☐ Female

Patient Address: .... GP Name: ....

.... Address: ....

Contact Number: (H).................... (W).................... (M) ....

Email Address: ....

Health Fund: .... Membership No: .... Card Ref No: ....

☐ Self Insured (estimate required) ☐ TAC ☐ W/C ☐ DVA Number: ....

Has the patient been in JMPH/SH previously? ☐ YES ☐ NO

Name previously admitted if different from above: ....

Has patient consent been signed and faxed/sent to bookings office? ☐ YES ☐ NO

Diagnosis ....

....

Allergies ....

....

Co- morbidities ....

....

Pre-Admission Investigations ....

....

On Admission Orders ....

....

....

Fasting Instructions ....

Anticoagulation Instructions ....

Expected Date of Delivery ....

NVD ☐ LUSCS ☐

Medication requirements on admission

PHARMACEUTICAL	ADMIN DATE	DOSE	ROUTE	FREQ.

Admission Date ....

Admission Time ....

Estimated length of stay ....

☐ JICU ☐ HDU ☐ Image Intensifier

☐ IOUS ☐ CUSA ☐ Stealth ☐ Microscope

Procedure(s) ....

....

Operation Date ....

Theatre Booking Required ☐ YES ☐ NO

PROCEDURE ITEM NUMBERS

....

....

PROSTHETIC ITEM NUMBERS

....

....

Has the patient been advised of all prosthetic items known to be used in the above procedure(s)? ☐ Yes ☐ No

Has the patient been advised that a gap or full fee may be payable on the above prosthetic items? ☐ Yes ☐ No

....

DOCTOR'S SIGNATURE DATE

ADMISSIONS PACK - PATIENT BOOKING FORM (1) MRD04(I)

Affix Patient Identification Label

Unit Record Number: ....

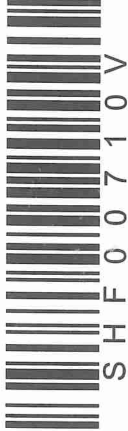
Surname: ....

Given Name: ....

D.O.B: .... Age: .... Sex: ....

Address: ....

....



PATIENT CONSENT

I, [ ] have been advised of the need for following procedure, [ ]

being performed on myself or [ ]

1. I consent to the procedure as described to me being performed;
2. I understand the nature of the proposed procedure;
3. I understand the material risks and complications associated with the proposed procedure;
4. I understand an anaesthetic, medicines or blood and blood products may be needed and that all of these involve some risk;
5. I understand that additional procedures may be needed if something unexpected happens;
6. I understand that health information relevant to the proposed procedure will be provided to Jessie McPherson Private Hospital so the necessary treatment is received. Jessie McPherson Private Hospital will also be advised about the contact details of the patient's general practitioner who may also be provided with relevant information about my condition and the proposed procedure.

Additional information relevant to consent (optional):

____

____

____

____

Patient/Representative: *Signature:* *Date:* / /

Relationship to patient: [ ]
(if applicable)

CLINICIAN

Name (PLEASE PRINT):		*Signature:*
Discipline:	*Designation*	
☐ *Surgical*	☐ *Consultant*	
☐ *Anaesthetics*	☐ *Registrar*	*Date:* / /
☐ *Medicine (Adult/Paeds)*		
☐ *Other*		

Written information about procedure given to patient ☐ Yes ☐ No

Treating Unit: [ ]

Interpreter required ☐ **Yes** ☐ **No** **If yes, language** ....

Interpreter used ☐ **Yes** ☐ **No** ☐ **Not applicable**

If required but not used reasons for not using ....

Name of interpreter .... **Signature** ....

MRD04(I)A
01/15

CONSENT FORM

MRD04(I)A