DETACH FROM BOOKLET

ST LUKE'S CARE
PRIVATE HOSPITAL

PRE-ADMISSION FORM

UR No.: Admission No.:

Surname:

Given Names:

Date of Birth: / / Gender:

Doctor:

DOCTOR TO COMPLETE

To be completed by Doctor. Please PRINT clearly.

PLEASE ADMIT

Title: Name: Surname:

Date of Birth: / / Gender: ☐ Male ☐ Female ☐ Non-binary or ☐ Preferred term

Address:

Telephone (Wk/Day): (Home): (Mobile):

OPERATION AND CLINICAL DETAILS

Date of admission: / /

Allergies:

Additional medical conditions:

Proposed operation/procedure/treatment:

Provisional diagnosis:

Date of operation: / / Estimated time in operating theatre:

Item numbers:

Expected length of stay: ☐ Day Only ☐ Overnight or longer Number of days:

Patient for Rehabilitation post operatively? ☐ Yes ☐ No

If yes, at St Luke's? ☐ Yes ☐ No (please specify location):

SPECIFIC ORDERS ON ADMISSION

Blood group and hold: ☐ to be attended on admission ☐ I have already arranged with:

Blood cross match: ☐ to be attended on admission ☐ I have already arranged with:

Thromboembolism prophylactic measures to be initiated on admission: ☐ Yes ☐ No

Details:

Other instructions/investigations on admission (e.g. medications, pathology, x-rays, ECG etc.):

Please note that ordering equipment is the responsibility of the surgeon.

Specific surgical equipment requirements (e.g. loan sets, prostheses, implants):

Name of company equipment ordered from:

Gap prostheses or non-rebatable item to be used: ☐ Yes ☐ No

If yes, I confirm the patient has been informed of the cost and reason for the choice of this item: ☐ Yes ☐ No

PRE-ADMISSION FORM

MR1

TAE - SLC 060123

DOCTOR AND PATIENT TO COMPLETE

PRE-ADMISSION FORM

MR2

ST LUKE'S CARE

PRIVATE HOSPITAL

CONSENT FOR MEDICAL AND/OR SURGICAL TREATMENT

UR No.: Admission No.:

Surname:

Given Names:

Date of Birth: / / Gender:

Doctor:

PROVISION OF INFORMATION TO PATIENT **To be completed by Medical Practitioner**

I, Dr (please print):

have discussed with this *patient/patient's parent/guardian/person responsible the various ways of treating the patient's present condition including the following proposed operation/procedure/treatment:

(insert site name and procedure or treatment - DO NOT USE ABBREVIATIONS)

I have informed this *patient/patient's parent/guardian/person responsible of the nature, likely results and material risks of the proposed procedure/treatment and of the matters in the section below.

Medical Practitioner's signature: Date: / /

Print name of Interpreter (if applicable):

Signature of Interpreter: Date: / /

PATIENT CONSENT **To be completed by patient**

I,

consent to the above operation/procedure/treatment to be performed on *me/upon my child/dependant

(Patient's name, if not self)

We have discussed the present condition and the various ways in which it might be treated, including the above procedure or treatment. The doctor has told me that:

- the procedure/treatment carries some risks and that complications may occur;
- an anaesthetic, medicines, or blood transfusions may be needed and these may have some risks;
- additional procedures or treatments may be needed if the doctor finds something unexpected;
- tissues and blood may be removed and could be used for diagnosis or management of my condition, stored and disposed of sensitively by the hospital or service providers;
- there may be recordings, photography or filming for the purposes of my clinical management;
- the procedure/treatment may not give the expected result even though the procedure/treatment is carried out

with due professional care;

I consent to anaesthetics, medicines, or other treatments which could be related to this procedure/treatment.

I consent to information regarding my condition being shared with other health professionals involved in my care e.g shared medical practitioners, allied health staff, community services or my General Practitioner.

I understand the nature of the procedure/treatment and that undergoing the procedure/treatment carries risks.

I have had the opportunity to ask questions and I am satisfied with the explanations and the answers to my questions.

I understand that I may withdraw my consent at any time prior to the treatment/procedure/operation.

☐ **I consent to a blood transfusion if needed**

OR

☐ **I do not consent to a blood transfusion**

Signature of patient/parent/guardian/person responsible

Print name of patient/parent/guardian/person responsible

Relationship to patient (if applicable) Date: / /

Delete where not applicable