KINGSGROVE DAY HOSPITAL

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# THEATRE BOOKING FORM

SURGEON: ANAESTHETIST:

## OPERATION DETAILS

PROPOSED DATE OF OPERATION: ______________________________________________

**PLANNED PROCEDURES:**

1.______________________________________________ITEM NO (IF APPLICABLE):__________________

2.______________________________________________ITEM NO (IF APPLICABLE):__________________

3.______________________________________________ITEM NO (IF APPLICABLE):__________________

4.______________________________________________ITEM NO (IF APPLICABLE):__________________

EXTRA ITEM NUMBERS IF ANY: ________________________________________________

PROSTHESIS REQUIRED (PLEASE CIRCLE. IF YES PROVIDE DETAILS): YES NO

______________________________________________________________________________________

TYPE OF ANAESTHETIC (PLEASE CIRCLE): GENERAL IV SEDATION LOCAL

ESTIMATED LENGTH OF SURGERY (HOURS/MINUTES):______________________________________________

## PATIENT DETAILS

SURNAME: _____________________________________ GIVEN NAME:______________________________

EMAIL: _________________________________________________________________________________

DOB: ____________________________________ CONTACT NUMBER:______________________________

MEDICARE NO: ___________________________________________________________________________

HEALTH FUND (IF APPLICABLE): _____________________ MEMBERSHIP NO:____________________________

KNOWN ALLERGIES/ MEDICAL HX. ________________________________________________________

## PAYMENT DETAILS

THEATRE FEES TO BE COLLECTED FROM (PLEASE CIRCLE): SURGEON PATIENT

ADDITIONAL REQUESTS: