MACQUARIE UNIVERSITY HOSPITAL

Pre Admission Booklet

3 Technology Place, Macquarie University NSW 2109

Please complete surname and D.O.B as a minimum.

UR

Surname

Given name

Date of birth

DAY ONLY HOSPITAL BOOKING FORM

Doctor to complete and fax to Hospital Bookings on +61 2 8088 6135 or forward to MUH.

1. PATIENT DETAILS

Title: Mr / Mrs / Ms / Miss Other (please specify)____________________

Given Names

Surname

DOB

Sex: M / F

Previous Name/s

Street Address

Suburb

State

Postcode

Home Phone

Work Phone

Mobile Phone

2. ADMISSION / PROCEDURE DETAILS

Admission date

Provisional Diagnosis

Planned procedure(s)

☐ LA

☐ Sedation

☐ GA

☐ Other

CMBS item number(s)

Estimated time for procedure (mins)

Health fund provider

Membership number

Patient to attend MUH Pre Admission Clinic? ☐ Yes ☐ No

3. EQUIPMENT AND PROSTHETIC DETAILS

Name of Implant

Name of company

Company contacted ☐ Yes ☐ No

Will the prosthesis attract a gap payment? ☐ Yes ☐ No If Yes, gap estimate $__________

Has informed financial consent been provided? ☐ Yes ☐ No Patient signature ____________________

4. PRE-OPERATIVE INVESTIGATIONS / TESTS

Please organise the following tests: ☐ Pathology ☐ Radiology ☐ Nuclear Medicine ☐ ECG

Required test(s) ____

Could this patient be pregnant? ☐ Yes ☐ No

Tests to be performed prior to admission? ☐ Yes ☐ No

Copies to

5. VMO / MACQUARIE UNIVERSITY HOSPITAL ACCREDITED PRACTITIONER

Name

Provider No.:

Signature

Date

BINDING MARGIN
DO NOT WRITE

DAY ONLY HOSPITAL BOOKING FORM

A2

3 Technology Place, Macquarie University NSW 2109

CONSENT FORM

Request/consent form for surgical operation procedure and/or medical treatment

Please complete surname and D.O.B as a minimum.

UR

Surname

Given name

Date of birth

1. PROVISION OF INFORMATION TO PATIENT

To be completed by the treating VMO / Macquarie University Hospital Accredited Practitioner.

I have informed

Given name of patient

Surname of patient

and/or

Guardian/person responsible (if applicable) /

Relationship (Father, mother, wife, etc.)

of his/her present condition, alternative treatments available and have explained the nature, purpose, likely results and the material risks of the following recommended operation/procedure(s).

Planned procedure(s)

Procedure site and side of body (no abbreviations)

Name of accredited interpreter (if applicable)

Language

☐ Sight translated (NSW) ☐ Verbally interpreted (NSW)

Treating VMO / Macquarie University Hospital Accredited Practitioner

VMO / Macquarie University Hospital Accredited Practitioner signature

Date

BINDING MARGIN DO NOT WRITE

CONSENT FORM

2. PATIENT CONSENT

The doctor whose name appears in Section 1 above and I have discussed my/my child's/my charge's present condition and the various alternative ways in which it might be treated. The doctor has told me that:

- The administration of an anaesthetic, medicines, and/or a blood transfusion may be needed in association with this operation/ procedure and/or treatment and these carry some risks.
- Additional procedures or treatment may be needed if the doctor finds something unexpected and I agree to these additional operations/procedures and/or treatments being carried out if required as long as they are related to the primary procedure set out in Section 1.
- Even though the operation/procedure and/or treatment is carried out with all due professional care, the operation/procedure and/or treatment may not give the expected result.
- The operation/procedure and/or treatment carries some risks and I understand that complications may occur.

I have been given the opportunity to ask questions of the doctor whose name appears above and understand the nature of the procedure/treatment and that undergoing the operation/procedure and/or treatment carries risk.

I am satisfied with the answers and information I have received.

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

I ☐ **do not** consent to tissue being used for any medical, therapeutic or scientific purposes, in addition to purposes related to the diagnosis or management of my condition. (Tick if applicable) Under the Human Tissue Act 1993.
(For further information, please refer to section 33 of the DOH Circular 2004/84).

I ☐ **do not** consent to a blood transfusion if needed. (Tick if applicable)

I request, understand and consent to the operation/procedure and/or treatment as outlined above in Section 1.

I ☐ **do not** consent to identifying clinical photography or video recording being taken or being retained in the course of my treatment for research and teaching purposes. (Tick if applicable)

Name of patient/parent/guardian

Signature

Date

B1