

Request for Surgical Operation, Procedure and / or Medical Treatment

ADMITTING DOCTOR	SURNAME	CHRISTIAN NAMES
PATIENT HISTORY/Summary of Physical Exam 1. <input type="checkbox"/> Healthy Patient 2. <input type="checkbox"/> Mild Systematic Disease – no functional limitations 3. <input type="checkbox"/> Severe Disease with definite functional limitations 4. <input type="checkbox"/> Severe Disease that is a constant threat to life	ADDRESS	
	POSTCODE	
Other comments:	PHONE	D.O.B
	SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	
Relevant Infections MRSA <input type="checkbox"/> VRE <input type="checkbox"/> Hep B or C <input type="checkbox"/> HIV <input type="checkbox"/>	DATE OF ADMISSION/...../.....	OPERATION DATE/...../.....
	ESTIMATED STAY	
	LA <input type="checkbox"/>	GA <input type="checkbox"/> Neurolept <input type="checkbox"/>
	HEALTH FUND	MEMBERSHIP NUMBER

Known Allergies:

Provisional Diagnosis:

Other Conditions Present/History of Complications / Aspirin Non-Steroidal Antiflammatory

.....

Proposed Operation/Treatment:

.....

..... Item No. (if known)

Prostheses Required: Yes No Prostheses Informed Financial Consent given: Yes No

Specific Pre-Operative Instructions (incl Instrumentation) :

..... Chest X-ray

..... Pathology

..... ECG

Date/...../..... Medical Officer's Signature:

Dear Doctor, please fax this completed page immediately to hospital
Fax - 9632 8480 or email holroyd.info@iphoa.com.au

I
of
request that the following operation / procedure
.....
be performed *upon me/upon

Following a discussion of *my/the patient's present condition, including the nature and likely results of the operation/procedure, I accept the professional opinion of Dr. that this is the appropriate operation/procedure.

I also request and consent to the administration of anaesthetics, medicines, blood product transfusions or other forms of treatment normally associated with this operation/procedure. I understand that other unexpected operations/procedures may be necessary and request that these be carried out if required. Although this operation/procedure is carried out with all due professional care and responsibility, I understand that in some circumstances the expected result may not be achieved.

I also understand that complications may occur with any operation/procedure and I accept the possible risks associated with this operation/procedure. The possible complications, risks and benefits have been explained to me by Dr.

DAY SURGERY/ENDOSCOPY PATIENTS ONLY

I understand that if I am discharged on the same day as my anaesthetic/sedation and my surgery/procedure, I should not drive a motor vehicle or operate machinery or potentially dangerous appliances, drink alcoholic beverages or make critical decisions for 24 hours.
I also understand that I must be accompanied home by a responsible adult.

* Delete as required

.....

SIGNATURE OF PATIENT/GUARDIAN/RELATIVE/ATTORNEY

.....

DATE

.....

*SIGNATURE OF WITNESS *Witness to signature only

.....

FULL NAME OF WITNESS

BINDING MARGIN – NO WRITING