StVincent's LISMORE

Date of Admission:
Date of Surgery:

PRE – ADMISSION CLINICAL REFERRAL

TO BE COMPLETED BY THE MEDICAL OFFICER

Surname: _____ First Name: _____ D.O.B: _____

Attending Medical Officer: _____

Provisional Diagnosis: _____

Proposed Operation/Treatment: _____

Explained to patient and consent complete: ❑ Estimated Operating Time: ____ Hours _____ Minutes

LENGTH OF STAY: Please note all patients will be admitted on the **day of their procedure** unless a suitable reason is provided.

❑ Admit _____ day/s prior to procedure. **Reason:** _____

❑ **DAY ONLY SURGERY** _____

❑ **1 NIGHT** (Extended Day Only 23 hours) _____

❑ **> 1 NIGHT Est. Length of Stay** _____ **Nights**

ANAESTHETIC INFO:

❑ Suitable for Local Anaesthesia ❑ HDU Bed required

❑ Cease Aspirin _____ Days Preop ❑ Cease Clopidogrel _____ Days Preop

❑ Anticoagulant Medication _____ Cease _____ Days Preop

❑ Diabetic Medication _____ Cease _____ Days Preop

This patient requires a pre-operative anaesthetic consult Yes ☐ No ☐

ALLERGIES (Drugs, Latex, Dressings):

CO-MORBIDITIES:	**CURRENT MEDICATIONS**

INVESTIGATIONS REQUIRED (apart from routine Preop guidelines):

OTHER PREOP INSTRUCTIONS / TREATMENT ON ADMISSION / EQUIPMENT REQUIRED:

Name: (Please Print) _____ Designation: _____

Signature: _____ Date: _____

BINDING MARGIN - DO NOT WRITE