ST VINCENT'S HEALTH AUSTRALIA

BOOKINGS/ PRE-ADMISSION REFERRAL FORM

URN ..... Visit No .....
Surname .....
Given Names ..... Sex .....
Date of Birth ...../...../.....
Admission Date ...../...../.....
Treating Doctor .....
Affix UR Label

SURGEON:..... ANAESTHETIST:.....

PHYSICIAN ☐ NO ☐ YES - NAME:.....

ADMISSION DATE: ...../...../.....

PATIENT DETAILS (OR AFFIX LABEL)

Surname: ..... First Names:..... Date of Birth: ...../...../.....

Patient Phone: Home..... Mobile:..... Business:.....

Admission Date: ...../...../..... Time: ..... Operation Date: ...../...../..... ☐ Day Case ☐ Overnight

Previous Admission to St Vincent's ☐ Yes ☐ No Date: ...../...../.....

Health Insurer: ..... Number: .....

Self / Uninsured ☐ DVA ☐ WC ☐ TAC / Motor Vehicle Other _____

Procedure: .....

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Anaesthetic: ☐ General ☐ IV Sedation ☐ Local

MBS Item Number:.....

Post Op Requirements? ..... ☐ ICU Bed ☐ HDU Bed

EQUIPMENT / PROSTHESIS / OTHER REQUIRED

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PRE-OP INVESTIGATIONS

*NOTE: Referral to Physician will include Pathology

PATHOLOGY: ☐ REQUIRED ☐ ARRANGED SERVICE PROVIDER .....

☐ FBE ☐ U&E / CREAT ☐ GROUP & HOLD ☐ GLUCOSE ☐ INR

☐ Cross Match - No. of Units.....

☐ MSU ☐ ECG

☐ CXR ☐ OTHER .....

RADIOLOGY

Signature:.....

Print Name & Designation: ..... Date: ...../...../.....

BOOKINGS/ PRE-ADMISSION REFERRAL FORM

MR-2A

SVPHM
P353A
04/17
49321