Ramsay
Health Care

ADMISSION REFERRAL FORM

TO BE COMPLETED BY DOCTOR
Please PRINT clearly in block letters.

UR: .....
Surname: .....
Given Names: .....
Date of Birth: ..... Sex: .....

Please Admit

Mr, Ms, Mrs, Dr, Miss, Master: ..... (Surname) ..... (Given Names)

Address: .....

Telephone: ..... (Home) ..... (Business) ..... (Mobile)

Date of Birth: ..... / ..... / ..... Sex: .....

Admission Details

Facility to be admitted to: .....

Proposed operation/treatment: .....

.....

Date of Admission: ..... / ..... / ..... **Expected length of stay:** ❑ Day Only ❑ Overnight or longer ..... nights

Date of Operation: ..... / ..... / ..... ICU request: ❑ Yes ❑ No Intubated: ❑ Yes ❑ No Image intensifier: ❑ Yes ❑ No

Indication for ICU: .....

.....

Estimated duration of operation: ..... **mins** **Type of Anaesthetic:** ❑ General ❑ Local

Clinical Details

Presenting Symptoms: .....

.....

Provisional Diagnosis: .....

.....

Other conditions present: .....

.....

Infection Risk: ❑ Yes ❑ No History of MRSA ❑ VRE ❑ Other: ..... VTE Risk: ❑ High ❑ Low

CURRENT MEDICATIONS: .....

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Is the patient taking any oral anticoagulants or antiplatelet medications? ❑ Yes ❑ No **If Yes, date when ceasing:** .....

History of Diabetes: ❑ Yes ❑ No If yes, what type?: ❑ Type 1 ❑ Type 2 Treated by: ❑ Insulin injection ❑ Tablet ❑ Diet

ALLERGIES: .....

Expected Item Number(s):

Equipment Details:

Implantable device: ☐ Implanting Device ☐ Removing Device

Type: Company: ☐ Contacted	Type: Company: ☐ Contacted

Will the prosthesis used attract a gap payment? ☐ No ☐ Yes If so, gap estimate $_____

Has informed financial consent been provided? ☐ Yes ☐ No Patient Signature.....

Pre-operative instructions (including tests required):

- ❑ Pre-admission clinic attendance required.
- ❑ Pathology tests: .....
- ❑ Investigations: ❑ xray/ultrasound ❑ ECG ❑ Other .....
- ❑ Anaesthetic Consult
- ❑ Drug Orders on Admission (drug order valid 24 hours only) .....

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- ❑ Special Instructions: .....

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Obstetric Details:

Parity: ..... EDC: ...../ ...../ ..... Blood Group: ..... Rh: ..... Hb: .....

Anti-D & agglut screen: ..... Rubella HIA titre: ..... HBs Ag: .....

*Consent (over page) to be completed and signed

Admitting Doctor

Name: ..... Signature: ..... Date: ..... / ..... / .....

RHC100.20
Referral/Consent

DO NOT WRITE IN THIS BINDING MARGIN

Ver 1.4- 04/13

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