RHC100.20

Referral/Consent

Ramsay Health Care

ADMISSION REFERRAL FORM

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

UR No: _____

Surname: _____

Given Name: _____

D.O.B: _____ Sex: ☐ M ☐ F

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: Strathfield O Kareena O

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: .....

.....

.....

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: ☐ X-ray/ultrasound ☐ ECG ☐ Other .....

☐ Anaesthetic Consult

☐ Drug Orders on Admission (drug order valid 24 hours only) .....

.....

☐ Special Instructions: .....

.....

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: ..... DR BOB JANG Orthopaedic Surgeon ..... Signature: ..... Date: ../../..

DO NOT WRITE IN THIS BINDING MARGIN

ADMISSION REFERRAL FORM

RHC35

Ver 1.5- 01/19

Ramsay Health Care

SURGICAL CONSENT FOR TREATMENT (PRIVATE)

UR No: _____

Surname: _____

Given Name: _____

D.O.B: _____ Sex: ☐ M ☐ F

(Affix patient identification label here)

Consent for Treatment RHC100.15

PART A - PROVISION OF INFORMATION TO THE PATIENT

To be completed by the TREATING RAMSAY HEALTH CARE ACCREDITED OR EMPLOYED PRACTITIONER

I have informed ..... and/or
PRINT NAME OF PATIENT

..... / .....
GUARDIAN / PERSON RESPONSIBLE (IF APPLICABLE) RELATIONSHIP (EG. FATHER, MOTHER, HUSBAND, WIFE, PARTNER ETC)

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

Procedure/Treatment: .....

.....

.....

.....

.....

INSERT NAME, SITE AND REASONS FOR PROCEDURE OR TREATMENT, DO NOT USE ABBREVIATIONS.

- Side of procedure/treatment: ☐ Left ☐ Right ☐ Not Applicable
- I have explained to the patient that blood products/blood transfusions may be needed during or following the procedure. The potential risk and complications related to this have also been explained.
  ☐ Yes ☐ No ☐ Not Applicable
- The patient has consented to blood products/blood transfusions, if needed.
  ☐ Yes ☐ No ☐ Not Applicable

DR BOB JANG
Orthopaedic Surgeon

....
SIGNATURE OF MEDICAL PRACTITIONER PRINT NAME DATE

If interpreter present

....
SIGNATURE OF INTERPRETER PRINT NAME DATE

PART B - PATIENT CONSENT

To be completed by the PATIENT / Person Responsible

I acknowledge that I have consented to the procedure/treatment as detailed above.

- I understand the explanation the doctor gave me as to the need and benefits related to procedure/treatment detailed above;
- I understand the procedure/treatment carries some risk and complications may occur;
- I understand additional procedure(s) may be needed if the doctor finds something unexpected;
- I consent to anaesthetics, medicines or other treatments which could be related to this procedure(s)/treatment(s);
- I understand I am able to withdraw this consent at any time prior to the commencement of procedure/treatment;
- I understand clinical images may be taken as part of my clinical management and may form part of the Medical Record. I understand these images will not be used for any other purposes without my consent.

I request and consent to the procedure/treatment, described above:

....
PATIENT / RESPONSIBLE PERSON(S) SIGNATURE **DATE**

.....
PRINT NAME OF PATIENT / PERSON RESPONSIBLE

IF PERSON RESPONSIBLE SIGNS, STATE RELATIONSHIP TO PATIENT (EG. FATHER, MOTHER, HUSBAND, WIFE, PARTNER ETC)

DO NOT WRITE IN THIS BINDING MARGIN

SURGICAL CONSENT FOR TREATMENT (PRIVATE) RHC200