THE BAYS

PRE-ADMISSION CLINIC REFERRAL

MR NUMBER	______________________
SURNAME	______________________
GIVEN NAME(S)	______________________
DATE OF BIRTH	______________ SEX ______

Please fill in if no Patient label available

Fax to The Bays Hospital Pre-admission Clinic on 5970 5335 or email to preadmissionclinic@thebays.com.au

Referring Doctor: ______________________

Patient Name: ______________________

Patient Address: ______________________

Date of Birth: _____ / _____ / _______

Contact Phone N^{o}(s): ______________________

Previous Patient: ☐ Yes ☐ No

Operation: ______________________

Date of Admission: _____ / _____ / _______ Date of Surgery:_____ / _____ / _______

Expected Length of Stay ☐ Day Case ☐ Overnight ☐ Longer _______ nights

Physician: ______________________

Discharge Plan: ______________________

Please indicate the required items:

- ☐ FBE, U&Es, CREATININE
- ☐ ECG
- ☐ LFTs
- ☐ Other Bloods ______________________

- ☐ Cross Matched Blood
- ☐ Group & Hold Serum
- ☐ Clear Fluids 24 hours
- ☐ Bowel Prep: ☐ Colonlightly
  - ☐ Fleet ☐ Oral or ☐ Enema
  - ☐ Picolax/Picaprep
  - ☐ Other ______________________

- ☐ Stomal Therapy
- ☐ HDU Post-Op
- ☐ Resource Nutritional Supplement
- ☐ Rehabilitation

PAC use only

Appt Date: _______

Time: _______

Booked on ePas ☐

Letter sent ☐

Notified Physio ☐

Prostate Nurse ☐

Stomal Nurse ☐

Comments:

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DO NOT WRITE IN BINDING MARGIN

PRE-ADMISSION CLINIC REFERRAL MR/084