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°(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:

_____

_____

_____

DO NOT WRITE IN BINDING MARGIN

PRE-ADMISSION CLINIC REFERRAL MR/084