THE BAYS

PRE-ADMISSION CLINIC REFERRAL

MR NUMBER	
SURNAME	
GIVEN NAME(S)	
DATE OF BIRTH	SEX
HOSPITAL USE ONLY	Please fill in if no Patient label available

Email to: preadmissionclinic@thebays.com.au or Fax: 5970 5335

Referring Doctor: ____________________

Patient Name: ____________________

Patient Address: ____________________

Date of Birth: _____ / _____ / _______

Contact Phone N°(s): ____________________

Operation: ____________________

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

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

Physician: ____________________ Peri-op r/v: ☐ Yes ☐ No

Has pre-op pathology been arranged: ☐ Yes ☐ Not req. Path Provider: ________________

(N.B If patient requires a G & H or X-match please advise patient to have blood tests at Melbourne Path)

Does patient take anti-coagulants: ☐ Yes Anti-coag: ________________ ☐ No

If Yes, are they required to cease pre-op? ☐ Yes When: ______________ ☐ No

Please indicate the required items:

☐ HDU / ICU Post-Op

☐ Stomal Therapy

☐ Dietician Referral

☐ Rehabilitation

☐ Clear Fluids 24 hours

☐ Bowel Prep (rooms to arrange): ☐ Colonlightly

☐ Fleet ☐ Oral or ☐ Enema

☐ Picolax / Pico prep ☐ Other

PAC use only

Review Date &Time:

Booked on Epas: ☐

Pre-Admission education pack: At reception for collection: ☐ posted to patient ☐

Hospital paperwork: Portal complete ☐ Received ☐ complete portal on……....to deliver……..

Physician review: Yes ☐ No ☐ Physician: ……………......... Date of r/v: …/…../……

If applicable:

If HDU/ICU required, ICU NUM's and theatre bookings informed on: ……………….. ☐

Discuss the options of home and inpatient rehab (referral at r/v) ☐

Advise pt. to bring forearm crutches on admission ☐ Home equipment (home rehab) ☐

THR - discuss the femoral head donation program (referral at r/v) ☐

DO NOT WRITE IN BINDING MARGIN

PRE-ADMISSION CLINIC REFERRAL MR/084