

## PATIENT DETAILS

Legal Name:  Date of Birth:  /  /

Date of Admission:  /  /  Time:

Referring Consultant:

ACC Contract  ACC Non-Contract Surgeon Lead Provider  Surgeon Contract, Non-Contract MercyAscot Lead Provider

## CONSULTANT TO COMPLETE

Diagnosis:

Planned Operation/Procedure:

Proposed Date of Surgery:  /  /  Operation Length:  Length of Stay:

Body Side: Left  Right  Inpatient:  Day Case:

I have explained to  the benefits and risks of the above planned operation/procedure.

Surgeon's Name:  Signature:  Date:  /  /

## PATIENT TO COMPLETE

I agree that I have received a reasonable explanation of the intent, alternatives, risks and likely outcomes of the operation/procedure of  to the  side of my body. In the event that something unexpected is found during surgery, I authorise the surgeon to act in my best interest.

I agree to the collecting of personal and health information from myself or my representative and authorise use of this information for purposes related to my health care.

In the event of a staff member receiving a 'needle stick injury' or other 'blood accident' from instrumentation used during my operation/ procedure/hospital stay, I consent to a blood sample being drawn from myself and tested for HIV (the AIDS virus), Hepatitis B, Hepatitis C and any other blood test deemed necessary by my doctor. I understand I will be informed of such testing and the results if I request them.

Patient/Guardian Signature:  Date:  /  /

(Please circle one).

## STAT MEDICATION ORDERS ON ADMISSION

Date	Drug	Dose	Route	Time	Authorised By	Given By	Time

Other preparations required (e.g. TEDs/SCDs), please specify:

## INVESTIGATION REQUIRED

Please tick either: A = Prior to Admission, B = On Admission, C = Not Required

Electrolytes	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	Coag Screen	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	MSU	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	Ordered at Labtests	<input type="checkbox"/>
Routine Haematology	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	Group & Ab Screen	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	ECG	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	Ordered at other lab	<input type="checkbox"/>
Urea & Creatinine	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	Cross match ____ units	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	X-rays (state)	<input type="text"/>		
(Other) _____	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	(Other) _____	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C				

PLEASE RETURN THIS FORM TO ASCOT HOSPITAL **AT LEAST ONE WEEK** PRIOR TO YOUR OPERATION/PROCEDURE DATE  
(csascot@mercyascot.co.nz or SEE PAGE 12 OF PATIENT INFORMATION BOOKLET)