

Western Health

# Request for Elective Admission

Please tick choice of site for admission and forward completed booking forms to booking office

- Western Hospital       Williamstown Hospital  
 Sunshine Hospital       Sunbury Day Hospital

PATIENT DETAILS OR IDENTIFICATION LABEL

- male       female

WH UR: \_\_\_\_\_  
 SURNAME: \_\_\_\_\_  
 FIRST NAME: \_\_\_\_\_  
 DOB: \_\_\_\_\_ eg. 1/Feb/1975  
 \*\*\*Must be alphanumerical as shown above  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Email: \_\_\_\_\_  
 Medicare No: \_\_\_\_\_

	Elective Bookings	Medical Bookings
Enquiries	8345 1947	8395 9120
Fax	8345 6205	8395 9199
Email	Electivebookings@wh.org.au	MedicalMaduBookings@wh.org.au

- Nominated Consultant Only  
 Unit Consultant  
 Any General Surgery Unit  
 Fellow/Registrar  
 Available on short notice  Yes  
 Interpreter Required  Yes

Admission Referred by:  Emergency     OPD     Rooms

**Urgency Category**

- Category 1**  
 Admission within 30 days is expected for a condition that has the potential to deteriorate quickly to the point that might become emergency.
- Category 2**  
 Admission within 90 days is expected.
- Category 3**  
 Admission within 365 days is expected.

Date of request      Requesting Unit      Admit under doctor

**Provisional Diagnosis** (please print) \_\_\_\_\_

**BMI** (Required)

<18.5      Underweight  
 18.5-24.9      Normal  
 25-29.9      Overweight  
 30 - 39.9      Obese  
 40+      Extremely Obese

**Treatment/Procedure/Operation** (please print) \_\_\_\_\_

**Type of Anaesthesia anticipated** \_\_\_\_\_

Admission Details	Type	Time required for procedure LOS _____/days	Hours / Min
<input type="checkbox"/> Public <input type="checkbox"/> Workcover <input type="checkbox"/> Private <input type="checkbox"/> TAC <input type="checkbox"/> Overseas Visitor <input type="checkbox"/> Veteran Affairs - DVA	<input type="checkbox"/> Day case <input type="checkbox"/> ICU / HDU <input type="checkbox"/> Multi day <input type="checkbox"/> Admit day prior (give clinical indication) <input type="checkbox"/> Ready for Surgery <b>Not Ready for Surgery</b> <input type="checkbox"/> Clinical <input type="checkbox"/> Personal		

**Relevant Medical History:**

Allergies (please specify)       Cardiac disease  
 Diabetes (type)       Warfarin/Aspirin/Clopidogrel  
 Resp

**Special requirements:**

X-Ray     Pathology     Instruments/Prosthesis/Equipment       Bowel Prep  
 Frozen Section       Other

GP DETAILS	Collection Statement
<b>CONTACT DETAILS</b> Name: _____ Address: _____ Phone: _____      Fax: _____	Patient consents hospital to contact GP nominated and inform GP about their condition, proposed procedure and that they have been placed on the Surgery Waiting list. Opt out <input type="checkbox"/>

Signature of Medical Officer requesting Admission: \_\_\_\_\_ Date: \_\_\_\_\_  
 Surname of Medical Officer: \_\_\_\_\_ Contact Number: \_\_\_\_\_ Pager: \_\_\_\_\_

**Office Use Only**

Pre-Admission clinic appt	Admission Date	Theatre Booked for	Patient notified
Date: ____/____/____ Time: _____		Date: ____/____/____	Date: ____/____/____

**Please Note: Incomplete or illegible booking forms will not be accepted by the bookings office.**  
**Patient's Forms that are ticked Category 1 may be faxed to 8345 6205 or emailed to electivebookings@wh.org.au**  
**All Original copies must be mailed to bookings office to be processed. Western Health, Elective Booking Office, 160 Gordon Street, Footscray, 3011**

WHAD32

Request for Elective Admission

WHAD32

male

female

# Request for Elective Admission

*RACS Sticker to be placed here.*

WH UR: \_\_\_\_\_

SURNAME: \_\_\_\_\_

FIRST NAME: \_\_\_\_\_

DOB: \_\_\_\_\_ eg. 1/Feb/1975)

**\*\*\*Must be alphanumerical as shown above**

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Medicare No: \_\_\_\_\_

## Western Health Waiting List Referral and Consent for Procedure(s)

I, \_\_\_\_\_ understand that I will be referred for placement on the hospital's wait list and give my consent for the

given name

surname

following \_\_\_\_\_  
specify operation(s) / procedure (s)

being performed on \_\_\_\_\_  
myself or name and relationship to patient if completed by person other than patient

### I have been advised and understand that:

- a) I will receive written confirmation of waiting list placement from the hospital. I also understand I may receive my surgery at another Western Health campus by a different surgeon than the surgeon referring me to the waiting list.
- b) I understand that at times representatives of medical device and prosthetic suppliers may be present during my procedure.
- c) If I have further questions about my condition and/or the above procedure(s), I will have the opportunity to discuss them with doctors at the hospital.
- d) If I am concerned about any changes in my condition or health, that occurs whilst I am on the waiting list I should contact my General Practitioner for advice.
- e) If I have any further questions regarding placement on the waiting list, I should contact the Booking Office at the relevant hospital.
- f) I also consent to such further operative procedures as may be found necessary to be performed during the course of the operation(s) / procedure(s) stated above. In conjunction with the above stated operation(s), I consent to the administration of such anaesthetics as may be considered by the anaesthetist to be necessary or advisable.
- g) I understand that during the procedure photographs of the procedure or of operative findings may be obtained. I understand that such photos will be regarded as part of my medical record and used ethically for teaching and clinical meetings where appropriate.
- h) If I have elected to be a public patient I understand that a registrar may perform the procedure or give the anaesthetic under the supervision of the consultant specialist.
- i) I understand the proposed procedure and that in the case of significant delay in time from addition to the wait list and surgery, consent may need to be reobtained or confirmed.

Risks and Complications discussed include: \_\_\_\_\_

Other options for treatment have been discussed with me  No  Yes

I have been given the consent information sheet for the surgery/procedure above  No  Yes

Signed: \_\_\_\_\_ Self or relationship to patient \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Reason if consent given by person other than patient: \_\_\_\_\_

Name of Interpreter

Reason for the person other than qualified interpreter

### Confirmation by Medical Officer

I, \_\_\_\_\_ have explained to the \*patient / person responsible for the patient, the nature of the above operation(s) / procedure(s). In my opinion, \*\*he / she understood the explanation.

\*\*Strike out not applicable

Signature of Medical Officer \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Consent obtained via telehealth consultation (tick if applicable)