|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| PATIENT DETAILS | | | | | | | | ADMITTING CONSULTANT | | | | | |
| Gender: | | | | | | | | Print Name: Professor Paul Neary | | | | | |
| MRN: [Mrn1] | | | | | | | | Signature: | | | | Date: [Date] | |
| Surname: [SurName] | | | | | | | | IMC number: 16270 | | | | | |
| Forename: [FirstName] | | | | | | | | PROCEDURE DETAILS | | | | | |
| Date of Birth: [DOB] | | | | | | | | Perioperative Diagnosis: | | | | | |
| Phone Number: [HomePhone] / [Mobile] | | | | | | | | Admission Date:[AdmDate] | | | Procedure Date:[OpDate] | | |
| Email: [Email] | | | | | | | | Procedures code: [OpCode] | | | | | |
| Address: [PatientAddress1] | | | | | | | | Procedure Description: [OpDescription] | | | | | |
| [PatientAddress2] [PatientAddress3] | | | | | | | |  | | | | | |
| [PatientAddress4] | | | | | | | |  | | | | | |
| Next of Kin: [NextOfKin] | | | | | | | | Laterality: Left Right Bilateral | | | | | |
| NOK Phone No: [NextOfKinContact] | | | | | | | | ANAESTHETIC TYPE | | | | | |
| Insurance Company: [Insurance] | | | | | | | | GA LA Sedation Other | | | | | |
| Policy/ Member Number: [PolicyNo] | | | | | | | | Consumable: Yes No | | | | | |
|  | | | | | | | | Specify: | | | | | |
| Pre-Operative assessment: Yes No | | | | | | | | Day Case | Procedure Room | | | Theatre | Inpatient |
| If yes, Phone Pre-Op Clinic | | | | | | | | ICU Bed Other Specify: | | | | | |
| Allergies: | Yes | | No |  | |  | | Mobility: Mobile  Falls Risk  Hoist | | | | | |
| Latex Allergy: | Yes | | No |  | |  | | Psychosocial History: | | | | | |
| Infection Prevention: | Yes | | No |  | |  | |  | | | | | |
| Diabetes: | Yes | | No | Type I | | | II |  | | | | | |
| Elevated BMI: | Yes | | No |  | | | |  | | | | | |
| BLOOD TESTS REQUIRED? | | | | | | | | SCANS REQUIRED? | | | | | |
|  | | | | | | | |  | | | | | |
|  | | | | | | | |  | | | | | |
|  | | | | | | | |  | | | | | |
| MEDICATIONS: | | | | | | | | ADDITIONAL INFORMATION: | | | | | |
| Anticoagulants: | | | | | Yes | No | |  | | | | | |
| Novel Oral Anticoagulants: | | | | | Yes | No | |  | | | | | |
| Discontinue prior to admission: | | | | | Yes | No | |  | | | | | |
| Patient informed: | | | | | Yes | No | |  | | | | | |
| Date of Discontinuation: | | | | | | | |  | | | | | |
| Relevant Other Medications: | | | | | | | |  | | | | | |
| MEDICAL HISTORY | | | | | | | | PHYSICAL EXAMINATION HISTORY | | | | | |
| Heart Murmurs | | Yes | No |  | | | |  | | Heart Sounds | | | |
| COPD | | Yes | No |  | | | |
| Asthma | | Yes | No |  | | | |
| Hypertension | | Yes | No |  | | | |
| ICD/Pacemaker | | Yes | No |  | | | |
| Epilepsy | | Yes | No |  | | | |
| Blood Disorder | | Yes | No |  | | | | Assessment Date: | | | | | |

**\*\*\*\*All fields on this form are mandatory and it must be completed in its entirety\*\*\*\***





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**Issue Date: September 2019**