

BOOKING FOR SURGERY

Please ☒ the appropriate item(s)

** Please complete this form and return by Fax **(3504-3683)** or e-Fax: opt_fax@cuhkmc.hk
[For enquiry, please contact OT on 3946-6780]

1. Patient Information (#Mandatory Information)

#Surname: _____ #Given Name: _____ Chinese Name: _____
#DOB: _____ (dd-mm-yyyy) Age: _____ #Sex: _____ CUMC No.: _____
HKID / Passport No.: _____ #Contact No.: _____
Email: _____

2. Procedural Information (#Mandatory Information)

#Surgeon: _____ Asst. Surgeon: _____
Anaesthetist: _____ Paediatrician: _____
#Category: ☐ Elective ☐ Emergency #OT/Procedure Location: ☐ Main OT ☐ Day Surgery
Any History of Other Hospital Admission Within Last 3 months: ☐ No ☐ Yes
Known Allergies: ☐ No ☐ Yes, please specify: _____

#Diagnosis: _____

#Operation: _____

#Operation Date: _____ (dd-mm-yyyy) #Time: _____ (am/pm)
Type of Anaesthesia: _____ #Duration: _____ hr(s)

Special Instrument / Equipment / Instruction:

☐ X-ray screening ☐ Frozen section

#Patient to be admitted on: _____ #Ward: _____ #Time: _____ (am/pm)

#Room Type: ☐ 4-bed (☐ Standard ☐ Seaview (only applicable to Medical Ward))
☐ Semi-private (☐ 1-bed ☐ 2-bed) ☐ Private (☐ Big ☐ Small) #Length of Stay: _____
☐ Deluxe ☐ Day Bed ☐ Droplet/ Airborne Isolation
☐ Contact Precaution

Booking Doctor's Signature

#Booking Doctor's Name

#Date (DD-MM-YYYY)

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