香港中文大學醫院
CUHK
Medical Centre

Please affix label here

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: ☐ Day Bed ☐ 4-bed (Standard) ☐ 4-bed (Seaview, only applicable to Medical Ward)
☐ Semi-private (1-bed) ☐ Semi-private (2-bed) ☐ Private (Big) ☐ Private (Small)
☐ Deluxe ☐ Droplet/ Airborne Isolation ☐ Contact Precaution

#Length of Stay: _____

Booking Doctor's Signature	#Booking Doctor's Name	#Date (DD-MM-YYYY)