

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: 1 bedded room 2 bedded room 4 bedded room #Length of Stay: _____

Booking Doctor's Signature

#Booking Doctor's Name

#Date (DD-MM-YYYY)

