

Please affix label here	

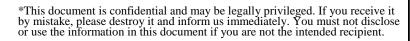
BOOKING FOR SURGERY

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 3946-6788]

#Surname:	#Given Name:		Chinese Name:	
#DOB:(dd-mm-yyyy)	Age:	#Sex:	CUMC No.:	
HKID / Passport No.:		#Contact No.:		
Email:				
2. Procedural Information (#M	andatory Informati	on)		
#Surgeon:		Asst. Surgeon: _		
Anaesthetist:		Paediatrician:		
#Category: □Elective □Eme	rgency #OT/Pro	ocedure Location:	☐Main OT ☐Day Surgery	
Any History of Other Hospital Adn				
Known Allergies: □No □Yes, pl	lease specify:			
#Diagnosis:				
#Operation:				
#Operation Date:			(am/pm	
Type of Anaesthesia:		#Duration	ı: hr(s	
Special Instrument / Equipment /				
, , , ,				
□X-ray screening □Frozen se	ction			
*Patient to be admitted on:		#Ward:	#Time:(am/pm	
#Room Type: 1 bedded room	□2 bedded room			
Booking Doctor's Signature	#Book	ing Doctor's Name	#Date (DD-MM-YYYY)	





OPT-REQUT-011-E-V02-20210705