

HCA Clinical Booking Information

The Princess Grace Hospital
Fax back on 020 7908 2135

For endoscopy bookings please telephone:
020 7908 2185
and fax the booking form to:
020 7908 2088

For Completion by Consultant - Please phone reservations on 020 7908 2130/1 to confirm bed and theatre availability before faxing
If this information is not provided we regret the booking cannot be accepted, incomplete forms will be returned

1. ABOUT THE PATIENT

Title: Forename: Address: Postcode:	Surname:	Date of Birth: Male <input type="checkbox"/> : Female <input type="checkbox"/> : Contact phone number: Is this: Home <input type="checkbox"/> : Work <input type="checkbox"/> : Mobile <input type="checkbox"/> : Other <input type="checkbox"/> :	Nationality:
Name of referring GP/doctor: Referring GP/doctor Address: Postcode: 2 nd GP (if not referral source): 2 nd GP Address:	Postcode:	Previously Treated at this /other HCA Hospital? Yes No If Yes, MR number If known: X G number (PGH reservation staff use) Interpreter needed please indicate language: Access assistance please specify: Dietary request please specify:	

2. ABOUT THE TREATMENT

Consultant Surgeon/Physician: Contact Number: Anaesthetist:	Admission Date: Procedure Date: Length of Stay:	Time: Time:
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A copy of the medical notes or a clinical letter giving this information will suffice. For elective admissions this information is required at least 24 hours prior to admission.

Diagnosis:

Procedure: **OPCS code:**

Relevant Medical History:

Allergies/Current medication (please ask patient to bring medication with them):

THEATRE PLANNING

Special requests for theatre: Approx. time required in theatre:

ITU/HDU required: Yes No Image required: Yes No .

Has Autologous Blood been taken? Yes No

TESTS ON ADMISSION (Please note: tests will not be arranged unless the Consultant completes and signs this form.)

FBC : U & E : LFTs : Clotting : Group & Save : X MatchUnits: Sickle : ESR : MSU : PTT : Platelets : Fasting Lipids : Glucose :
Fasting Glucose : Cardiac Enzymes : ECG : Chest X-Ray : Other Radiology : Physio : Shave : Bowel prep : Additional Request Forms attached :

3. ABOUT THE ACCOUNT

Self pay? <input type="checkbox"/>	Please be aware that payment is due on or before admission.	Quote requested <input type="checkbox"/>
Insured? <input type="checkbox"/>	Insurance company	Policy number:
Other sponsored? <input type="checkbox"/>	Sponsor (e.g. embassy, company)	Reference No:

4. INFORMATION PROVIDED BY

Completed by (print):	Signature of Consultant/Test Authorisation: Consultant's full name (print clearly):	Date:
Confirmed telephone booking with (Hospital Staff name - only required if not a set session):		Date

5. FOR OFFICE USE ONLY

Received by (HCA staff member):	Date:
Booking Accepted	Rejected By: Date:

Consultant Practice Consent: Data Protection Act 1998

THIS DOCUMENT REFERS TO THE PATIENT WHOSE DETAILS APPEAR ON THE REVERSE OF THIS FORM AND COVERS INFORMATION IN RELATION TO TREATMENT PROVIDED BY THE CONSULTANT WHOSE NAME APPEARS ON THE REVERSE OF THIS FORM.

The staff at this private practice are committed to meeting the provisions of the Data Protection Act 1998. Everyone working here has a legal duty to keep information about you confidential.

A copy of our Policy document is available on request.

Our Data Controller is the Consultant whose practice this is.

We ask for information about yourself so that you can receive proper care and treatment. We keep this information securely with details of your care because it may be needed when we see you again. You have a right of access to your health records. Sometimes the law requires us to pass on information, for example to notify a birth.

Some of this information is obtained to plan for the future, to see that the practice runs legally and effectively and can account for its actions, and to make sure that payment is made to the staff who look after you and for the facilities needed for your care.

You may be receiving care from other people as well as us. So that we can all work together for your benefit, we may need to share some information about you. We only ever use or pass on information about you if people have a genuine interest in you and your care.

Whenever we can, we shall remove details, which identify you. Law strictly controls sharing of some types of very sensitive personal information.

Please note that this form is not a consent for specific treatment. Such consent will be discussed with you at an appropriate point in your care.

I consent to provide information to my consultant above on the understanding that this information will be handled confidentially in accordance with the requirements of the Data Protection Act 1998.

I further consent for him/her to share that information with third parties for the purposes of arranging, providing and ensuring payment for that treatment.

I specifically consent to staff at the Princess Grace hospital specified and their colleagues making use of that information for the same purposes, on the understanding that staff within the HCA hospital group / other hospital are committed to handling patient information in accordance with legislation.

I consent to the staff of the named hospital providing information to staff at this practice that facilitates successful treatment of my condition.

I do not wish my information to be disclosed to:

any family member, any family member except:

Signed:

Print name:

Date: