BOOKING/PRE-OPERATIVE ASSESSMENT FORM

SECTION A | PERSONAL PARTICULARS

Full Name (Please CAPITALISE Surname/Family Name)		NRIC/Passport No.
Date of Birth (DD/MM/YYYY)	Gender	
Home Address		
Contact No. (Mobile)	Contact No. (Others)	E-mail

SECTION B | DETAILS ON PROCEDURE

TOSP Code and Description/Nature of Operation	
Date and Time of Operation	Duration of Operation (min)
Surgeon	Anaesthetist[1] ☐ Book for me

Type of Anaesthesia

☐ IV Sedation ☐ Local Anaesthesia ☐General Anaesthesia

SECTION C | ADDITIONAL INFORMATION

Equipment Required (e.g Image Intensifier/radiographer, special instruments, implants, consumables)

Special Instructions (e.g. fleet enema on arrival, laboratory investigations pre/post procedure, infusion)

SECTION D | BILLING INSTRUCTIONS

☐ Bill Patient

☐ Bill Clinic

☐ Bill Insurer (Integrated Shield Plans)[2]

- ☐ AIA ☐ Great Eastern ☐ HSBC Life
- ☐ Income ☐ Prudential ☐ Singlife

☐ Other Insurers/Corporate Plans[3] (Please specify):

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[1] Please note that due to contractual agreements with specific insurers/corporate payors, Foundation Ambulatory Centre may be required to assign pre-selected anaesthetists.
[2] Please ensure that you send a copy of the approved pre-authorisation or Letter of Guarantee along with the completed booking form.
[3] Subject to prevailing arrangement between Foundation Ambulatory Centre and respective corporate payors.

SECTION E | PRE-OPERATIVE ASSESSMENT

Height	Weight	BMI
m	kg	

Medical History

Does the patient have any history of:	YES	NO
1. Diabetes Mellitus[4]?	☐	☐
2. Infectious Diseases?	☐	☐
3. Cardiovascular diseases (hypertension, hyperlipidemia, ischaemic heart diseases, myocardial infarct, stroke etc.)	☐	☐
4. Implants (stents/pacemakers)?	☐	☐
5. Anti-platelet/Anti-coagulant therapy?	☐	☐
6. Asthma/Chronic Obstructive Pulmonary Disease (COPD)/Sleep Apnoea/Use of CPAP or other assistive respiratory devices/breathing machines?	☐	☐
7. Liver diseases?	☐	☐
8. Kidney disease on dialysis?	☐	☐
9. Drug Allergy (Please specify):	☐	☐
10. Issues with anaesthesia (difficult airway, malignant hyperthermia, family history of malignant hyperthermia etc.)	☐	☐
Is PRE-ADMISSION CLINICAL EVALUATION (PACE) REQUIRED?	☐	☐

Current Medication (if any):

☐ I confirm that for patients on anti-platelets/anti-coagulants, I will make the assessment as to whether to stop therapy before the procedure.[5]

☐ I confirm that no emergency blood supply is required.

Doctor's Name	MCR No.	Signature	Date

[4] Patients will require a capillary blood glucose on the day of operation
[5] Patients on warfarin will require an INR