

# HCA Clinical Booking Information - The Princess Grace Hospital

[reservations.pgh@hcahealthcare.co.uk](mailto:reservations.pgh@hcahealthcare.co.uk)

Please call reservations on 020 7908 2130/1 to confirm bed and theatre availability or endoscopy on 020 7908 2185

## 1. ABOUT THE PATIENT

**Title:** \_\_\_\_\_ **Surname:** \_\_\_\_\_ **Forename:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Postcode:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Nationality:** \_\_\_\_\_

Male:  Female:  **Contact number:** \_\_\_\_\_

Is this: Home :  Work :  Mobile :  Other :

Name of referring GP/doctor: \_\_\_\_\_

Referring GP/doctor address: \_\_\_\_\_

\_\_\_\_\_ Postcode: \_\_\_\_\_

2nd GP (if not referral source): \_\_\_\_\_

2nd GP Address: \_\_\_\_\_

\_\_\_\_\_ Postcode: \_\_\_\_\_

Previously treated at this /other HCA Hospital? Yes  No

If Yes, **MR number** If known: X \_\_\_\_\_

**G number** (PGH 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: \_\_\_\_\_

(**\*\*\*please cc anaesthetist when sending booking form\*\*\***)

**Admission date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**Procedure date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**Length of stay:** \_\_\_\_\_

**Anaesthetic Type:** *G/A L/A L/A & Sedation Sedation*

**Diagnosis:** \_\_\_\_\_

**OPCS Code**

**Procedure:**

**Relevant Medical History:** \_\_\_\_\_

**Allergies/current medication (please ask patient to bring medication with them):** \_\_\_\_\_

## THEATRE PLANNING

**Special requests for theatre:**

**Approx. time**

**in theatre:**

ITU required: Yes  No

HDU required: Yes  No

**Image required:** 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 Match .....Units: Sickle : ESR : MSU : PTT : Platelets : Fasting

Lipids : Glucose : Fasting Glucose : ECG : Chest X-Ray : Physio : Shave : other

**Pre- Assessment Pack Sent to patient**

## 3. ABOUT THE ACCOUNT

Self pay?  Please be aware that payment is due on or before admission. Quote requested

**Insured?**  **Insurance company:** \_\_\_\_\_ **Policy number:** \_\_\_\_\_

Other sponsored?  Sponsor (e.g. embassy, company)

Reference No: \_\_\_\_\_

## 4. INFORMATION PROVIDED BY

**Consultant's full name (print clearly):**

Signature of Consultant/Test Authorisation:

**Date:**

**Confirmed telephone booking with (Hospital staff name - only required if not a set session):**

**Date:**

**Received by (HCA staff member):**

**Date:**

**Booking accepted**

**Rejected by:**

**Date:**