FOR COMPLETION BY **Admitting DOCTOR**

REQUEST FOR ADMISSION

SYDNEY SPECIALIST DAY HOSPITAL

Level 5, 7 Help Street
Chatswood NSW 2067
Phone (02) 9386 0211
Fax (02) 9386 0258
ac@sydneyskinandvein.com.au

PATIENT DETAILS

Last Name: _____

First Name: _____

DOB: _____ Sex: _____

Phone Number: _____

Admitting Doctor: _____

Medicare

Medicare Number _____

Expiry _____

Health Fund No Health Fund ☐

Private Health Fund: _____

Membership Number: _____

CLINICAL DETAILS

Primary Diagnosis: _____

Significant Other Conditions: _____

Allergies: _____

Current Medications: _____

ADMISSION DETAILS ◯ Adult ◯ Paediatric

Proposed Operation: _____

Time Required: _____

Preferred Month/Dates *(Not guaranteed to be available):* _____

Procedural Item Numbers: _____

ANAESTHESIA

◯ General Anaesthetic

◯ IV Sedation

◯ No Sedation/ Local Anaesthetic

◯ Other:

SET UP

◯ Sterile

◯ Aseptic

◯ Special requirements:

ADMISSION PROCESS:

1. All communication with regards to patient admissions must be addressed to the **admission coordinator**, Kathy Dekker, on (02) 9386 0211.
2. Please return this form by email to ac@sydneyskinandvein.com.au
3. The admission request needs to be received at least 14 days before the proposed procedure date.
4. **The hospital will inform you of the available dates and once confirmed, the hospital will contact the patient.**
5. **Please do not confirm any dates with patients until the availability of the theatre list has been confirmed by the admission coordinator.**
6. A deposit of $1000 payable by the patient is required to secure the booking. A 7-day notice of cancellation is required otherwise the deposit will be retained. The deposit will be refunded on the day of the procedure.
7. Hospital admission fees are applicable for non(self)-insured patients. The fee will be estimated based on the procedural complexity, procedure time, implantable and prosthetics required.