Centurion Day Hospital

Quality Day Surgery

The Affordable Option

192A Glover Avenue Lyttleton Centurion ● PO Box 8015 Centurion 0046 ● Reg no: 98/02766/07 ● Practice number: 0207047

Tel +27 12 663 2010/1 ● Fax +27 12 663 1006 ● e-mail: info@centuriondayhospital.co.za ● www.centuriondayhospital.co.za

Questionnaire for Patients booked for General Anaesthesia

This information is crucial to the Anaesthetist

Name
Age
Weight

Do you suffer from any of the following?	**YES**	**NO**
Any Allergies		
Problems with previous Anaesthetic		
Heart condition: a cardiologist report will be needed		
High Blood pressure		
Tendency to bleed		
Using of blood thinning medication: Warfarin, Disprin, Anti Inflammatory		
Lung Condition		
Kidney condition		
Disability of any kind		
Epilepsy or blackouts		
Porphyria		
Malignant hyperthermia		
Medications taken currently: please mention all:		
Please *provide more information if you answered YES to any question?*		

Signature of parent/guardian/patient Date

This questionnaire must be sent to the hospital with the booking information.

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Email completed form to admissions@centuriondayhospital.co.za & cc ellen@centuriondayhospital.co.za

PRE-ADMISSION FORM: KINDLY FAX OR EMAIL FORM A.S.A.P.

Doctor's Information

Name of Dr: .... Practice number: ....

Date of Procedure: ....

Please complete – Full details of patient

Surname: .... Full names: ....

Sex: Male ☐ Female ☐ Date of birth: .... Dependent code: ....

Mobile number patient: ....

Preferred Language: English ☐ Afrikaans ☐ Other telephone numb: ....

Does patient suffer from any illness or condition: If so stipulate ....

What medication is the patient using? ....

Details- Main member of Medical aid

Medical aid name: .... Option ....

Member number: .... Title: Mr.: .... Mrs: .... Miss: .... Dr: ....

ID no of Main Member: .... Authorisation no: ....

Main member's surname: .... Full names: ....

Postal address: .... Physical address: ....

.... Code................

.... Code.................................... Tel (h) .... (w)...................................

Email: .... Mobile number: ....

Relation to the patient: ....

Employer's Detail (Main member)

Company name: .... Tel: (w) ....

Postal address of employer: .... Occupation: ....

.... Postal code: ....

Person to contact in case of emergency/Next of Kin (not someone that lives with you)

Surname: .... Initials: .... Title: ....

Tel: (W) .... Tel: (H) ....

Relationship to patient: .... Mobile number: ....

Main member

I, (full names) '..give Centurion Day Hospital the authority to claim/submit the account on my behalf to

.... (medical aid), Member number: .... Date: ....

.... ☐ I hereby confirm all details supplied are correct and true.
Signature