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.

Centurion Day Hospital
Quality Day Surgery

Centurion Day Hospital 192A Glover Avenue Lyttleton Centurion • PO Box 8015 Centurion 0046
Tel +27 12 663 2010 / 1 • Fax +27 12 663 1006 • e-mail: info@centuriondayhospital.co.za • www.centuriondayhospital.co.za

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: .....

Patient mobile number: .....

Preferred Language: English ☐ Afrikaans: ☐

NB!! Does patient suffer from any illness or condition: Stipulate .....

What medication is the patient using? .....

Person responsible for account

Title: Mr.: ..... Mrs: ..... Miss: ..... Dr: ..... ID no of person responsible for account: .....

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

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

.... Code: .....

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

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

Employer's Detail (Person responsible for payment of account)

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.....

Person responsible for account

I, (full names) `..... confirm all details supplied are correct and true.

.....
Signature