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| BOOKING FORM | | |
| PATIENT DETAILS | | |
| \*PLEASE STATE HERE IF THE PATIENT IS **DOUBLE VACCINATED** YES / NO | | |
| TITLE: | FORENAME(S): | SURNAME: |
| DATE OF BIRTH: |  | SEX: |
| **\*NHS NUMBER OR PASSPORT NUMBER: {NHS Number}** | | |
| RESIDENTIAL ADDRESS: | | |
| TELEPHONE: |  | MOBILE: |
| EMAIL: | | |
| ADMISSION DETAILS | | |
| SURGEON: |  | ANAESTHETIST: |
| DATE OF ADMISSION: |  | TIME: |
| DATE OF OPERATION: |  | TIME: |
| PROCEDURE(S): | | |
| OPCS CODE(S): **\*DIAGNOSIS (ICD-10):** | | ESTIMATED OPERATION LENGTH: |
| LENGTH OF STAY: ONS / DAYCASE | | NO. OF NIGHTS: |
| PAYMENT DETAILS | | |
| PAYMENT TYPE: CHARGE TO PATIENT CHARGE TO CLINIC INSURANCE | | |
| HOSPITAL FEE AMOUNT:  (please give breakdown) |  | PRICE CONFIRMED WITH BOOKINGS TEAM: YES / NO |
| INSURANCE COMPANY: | | MEMBERSHIP NO: |
| AUTHORISATION CODE: |
| LETTER OF GUARANTEE: | | |
| EXTRA REQUIREMENTS | | |
| Imaging Required: YES/ NO Type: | | |
| EQUIPMENT REQUIREMENTS: | | |
| PROSTHESIS/IMPLANT(S) REQUIREMENTS: | | |
| INVESTIGATIONS ON ADMISSION: | | |
| INTERPRETER: |  | WHEELCHAIR ACCESS: |
| DIETARY/ALLERGIES: |  | *OTHER:* |
| COMPLETED BY: |  | DATE: |

Please be aware that a cancellation charge of £500 will apply if HSSH are not informed in writing within 48 hours of the procedure.