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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.