Appendix 3: Operation and Interventional Radiology booking forms

ID label (**attach once available**) Name DOB Hosp. No. Named Consultant only ☐	☐ Miss Hulin ☐ Mr Lee ☐ Mr Metcalfe ☐ Mr Kuhan ☐ Mr Rittoo ☐ Mr Vlachakis ☐ Mr Watson ☐ Mr Wijesinghe
Procedure Free Text:- Or Tick ✓ on reverse of form	Procedure Free Text
R ☐ L ☐ Bilateral ☐ N/A ☐	Anaesthetic GA ☐ LA ☐

Booking – Surgical (mark all applicable)

Operation => suitable **inpatient** only ☐

Patient co-morbidity => suitable **inpatient** only ☐ (book to POA clinic)

Rapid referral (within 2 weeks) ☐	Urgent (within _______ weeks)	Routine ☐

Estimated duration of procedure (including anaesthetic time)

Additional comments/instructions Non standard theatre equipment ___________ ☐ Patient preparation e.g. anticoag management ☐ Image Intensifier _______________________ ☐ Implant _______________________ ☐ Microscope _______________________ ☐ Frozen Section _______________________ ☐ HDU/ITU Bed _______________________ ☐ **Estimated length of stay/days -**	FREE TEXT – Additional Comments

Surgeon completing form (print name) -

TO BE COMPLETED BY PRE-OP ASSESSMENT DEPT

Contact numbers	Any periods of non-availability -
Home	Patient will accept short notice ☐
Work	Morbidly obese patient (BMI >35) ☐
Mobile	Travel problems (earliest time to get to RBCH)
Email	
FREE TEXT	

EMERGENCY ☐ URGENT ☐ ROUTINE ☐

Royal Bournemouth & Christchurch Hospitals NHS
NHS Foundation Trust

RADIOLOGY GUIDED PROCEDURE REQUEST

Date Received	Appt given

Patient Addressograph

SURNAME DOB

FORENAME

ADDRESS

TEL NO.

Referring hospital

Consultant	NHS/Private

INPATIENT/OUTPATIENT

If inpatient: Ward

GP

LMP/Breastfeeding

PROCEDURE REQUIRED **RIGHT** ☐ **LEFT** ☐ **BILATERAL** ☐

Anaesthetic required and reason:

LA ☐

IV SEDATION ☐

GA ☐

Clinical details and significant medical history

MDT REVIEW Y/N Date:

Radiologist discussed with:

Infection control risk? Y ☐ *N* ☐

Renal function eGFR < 30 ☐ eGFR > 30 ☐		FBC/INR requested	Y / N
Significant cardiac or pulmonary disease	Y / N	Is patient on aspirin	Y / N
Lung function FEV1>1	Y / N	Is patient on warfarin	Y / N
Malignancy	Y / N	If patient on warfarin why:	
Does the patient have myeloma	Y / N	AF	Y / N
Allergies (including contrast allergy)	Y / N	Venous thromboembolism	Y / N
If so, please state:		Metal heart valve	Y / N
		Is the patient on other anti-coagulants	Y / N
Diabetic on insulin	Y / N	or anti-platelet agents (ie. clopidogrel)	
Diabetic on oral medication	Y / N		

PRIMARY STAGE OF CONSENT (please indicate with a tick):

1. The reasons for this procedure and alternatives have been discussed with the patient and the patient understands and agrees with the discussed management plan YES ☐
2. Relevant patient information leaflets have been provided to the patient YES ☐
   (intranet link: http://rbhintranet/patient_information3/leaflets/leaflets.shtml)
3. Is there a language barrier that could compromise either stage of the consent process? If so please state language and actions taken to ensure understanding YES ☐ NO ☐
   Interpreter used ☐
   Language line used ☐
4. When the patient lacks capacity, the responsible clinician has completed a consent form 4, which will be confirmed by an IR Consultant YES ☐ N/A ☐

Secondary (procedural) consent will be performed by the operating clinician.

Responsible Consultant (Printed): .... Signature (Consultant/SpR only out of hours): .... Date: ....

CONTACT NAME AND BLEEP ....

Incomplete forms may cause a delay in treatment of your patient and may be returned to the consultant responsible to complete