**BRAEMAR HOSPITAL THEATRE BOOKING LIST** 

**Please email form to:**[***bookings@braemarhospital.co.nz***](mailto:bookings@braemarhospital.co.nz)**by 5pm on the Wednesday of the week prior to the procedure**

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| **SURGEON:** | | | **DATE:** | | **START TIME:**  **(NB: Team brief 15mins prior)** | | **ANAESTHETIST: ASSISTANT:** | |
| PATIENT DETAILS: | | ARRIVAL TIME / GP DETAILS: | | PROCEDURE DETAILS: | | SURGEON REQUIREMENTS  ie; EQUIPMENT/ SPECIALIST CONSUMABLE/ POSITIONING | | PATIENT NEEDS  DISABILITIES / ALLERGIES | |
| Name  Address  Phone  DOB  Email  NHI  ACC/Private /SX  Daystay/No of nights |  | Arrival Time:      GP Details: | | Anaesthetic type:  Expected length of procedure:    Special Care required? | | II Confirmed: Yes/No  II Provider: | |  | |
| Name  Address  Phone  DOB  Email  NHI  ACC/Private /SX  Daystay/No of nights |  | Arrival Time:    GP Details: | | Anaesthetic type:  Expected length of procedure:    Special Care required? | | II Confirmed: Yes/No  II Provider: | |  | |
| Name  Address  Phone  DOB  Email  NHI  ACC/Private /SX  Daystay/No of nights |  | Arrival Time:    GP Details: | | Anaesthetic type:  Expected length of procedure:    Special Care required? | | II Confirmed: Yes/No  II Provider: | |  | |

**PLEASE ENSURE ANY AMENDMENTS OR CANCELLATIONS ARE CLEARLY STATED. When calculating procedure time, please ensure anaesthetic / turn around time considered.**