Booking Request

Waiting Number:

MOH Number:*	**MRN:**	**ARO+:** no ☑ yes ☐ Specify:*			
Patient Name: (Last, First)*	**DOB:***	**Gender:***	**NOK:**	**Phone:***	**Alt:***
Street Address:*	**City:***	**Postal Code:***	**Admission Type:*** ☐ SDS ☐ SDAS ☐ SDAS/OBS ☐ Short Notice ☐ ICU Bed Req'd:		
Surgeon Name:*	**Referring Physician:**	**Family Physician:**	**Diabetic:*** ☐ yes ☐ no ☐ Type 1 ☐ Type 2	**BMI > 35:** ☐	
Diagnosis:*	**Allergies:*** ☐ no ☐ yes Specify:				

Procedure:*	**Specifications for procedure(s):**
Hip Total Arthroplasty Anterior	
Hip Total Arthroplasty Anterior	
Hip Total Arthroplasty Anterior	
Hip Total Arthroplasty Anterior	

Prosthesis/Special Equipment/Other Comments:

Position:* **Time Req.:***

- ☐ Bookwalter
- ☐ Ligasure
- ☐ Frozen Section
- ☐ Fluoroscopy
- ☐ C-ARM

Anesthetic Type:

Assist Request:

Pre-Admission Clinic/Day Surgery:

- ☐ No pre-op testing
- ☐ Hospital protocol
- ☐ Anesthetic Consult reason:*
- ☐ OT
- ☐ PT
- ☐ X-ray
- ☐ Other:

Requested Date for Surgery:

Surgeon Signature:

WTIS REPORTING REQUIREMENTS

Service Area:*	**Service Detail 1:***	**Resp. For Payment:***
Referral Type & Source:*	**Referral Date:***	**WTIS Wait 1 Priority Level:**
Consult Date:*	**Decision to Treat Date: ***	**WTIS Wait 2 Priority Level:**

Dates Affecting Readiness to Consult:

1. From: To:
2. From: To:
3. From: To:
4. From: To:

DARC Reason:

- ☐ Pre-Defined Follow-up
- ☐ Developmentally Appropriate
- ☐ Missed Consultation
- ☐ Inability to Contact Patient
- ☐ Medical Status Changed
- ☐ Patient Chooses to Defer

Wait 1 System Delay Reason:

- ☐ Lack of Hosp/Clinic Resource
- ☐ Patient Preference
- ☐ Prerequisites Not Completed
- ☐ Emergency Closures
- ☐ Resched – Higher Priority Case
- ☐ Surgeon Unavailability

OSMH USE ONLY

Dates Affecting Readiness to Treat:

1. From: To:
2. From: To:
3. From: To:
4. From: To:

DART Reason:

- ☐ Other Surgical Procedure
- ☐ Inability to Contact Patient
- ☐ Developmentally Appropriate
- ☐ Neo-Adjuvant Chemotherapy
- ☐ Pre-Defined Follow-up Interval
- ☐ Neo-Adjuvant Radiation
- ☐ Missed Surg/Procedure
- ☐ Patient Chooses to Defer
- ☐ Medical Status Changed

Wait 2 System Delay Reason:

- ☐ Resched – Higher Priority Case
- ☐ Emergency Closures
- ☐ Prerequisites Not Completed
- ☐ Patient Preference
- ☐ Lack of Hosp/Clinic Resource
- ☐ Surgeon Unavailability

Documentation:* ☐ yes ☐ no

- ☐ Consultation
- ☐ Consent
- ☐ Doctor's Orders

Date Received:	**OR Date:**	**PAC Date:**
Rescheduled Date:	**Reason for Change:**	

hospital ORILLIA SOLDIERS' MEMORIAL

Patient Identification Information

Evidence of Consent Form

EVIDENCE of CONSENT: To be completed by proposer of treatment IF Evidence of Consent IS NOT documented in the health record.

1. I have obtained consent from _____
PRINT name of patient or substitute decision maker (SDM)
(Contact Number for SDM:_____)
for such physicians, surgeons, anesthesiologists, health care learners and other health practitioners whose services are required, to perform the following treatment(s) and/or investigation(s):***(no abbreviations; where appropriate indicate side of the patient)***

Hip Total Arthroplasty Anterior	
Hip Total Arthroplasty Anterior	
Hip Total Arthroplasty Anterior	
Hip Total Arthroplasty Anterior	

upon _____
PRINT name of patient

2. I have explained the:
   - nature of the treatment
   - expected benefits of the treatment
   - material risks and side effects of the treatment
   - alternate courses of action **and,**
   - likely consequences of not having treatment

3. I have consent to perform any additional or alternative investigations, treatments or operative procedures that are immediately necessary in addition or in place of those authorized above

4. I have explained that the patient must refrain from driving a motor vehicle and avoid alcohol and sedatives for a minimum of 24 hours if a General Anesthetic or Conscious Sedation is used.

SIGNATURE OF PHYSICIAN / HEALTHCARE PRACTITIONER:

Signature of Physician / Healthcare Practitioner _____ Print Name _____ Date _____ dd / mm / yy

EMERGENCY TREATMENT WITHOUT CONSENT

I am proceeding with the emergency treatment(s) and/or investigation(s), identified on this consent because the patient meets the Conditions for Emergency Treatment without Consent outlined in the Health Care Consent Act and the Orillia Soldiers' Memorial Hospital, Consent Process Policy.

Signature of Physician/Healthcare Practitioner _____ Print Name _____ Date _____ dd / mm / yy

TELEPHONE CONSENT FROM PATIENT/SDM

I confirm that I have explained by telephone, the nature of the treatment(s) and/or investigation(s), the expected benefits, material risks, material side effects, alternative course of action and the likely consequences of not having the treatment(s) to _____ and addressed all questions.
Patient /Substitute Decision Maker

Signature of Physician/Healthcare Practitioner _____ Print Name _____ Date _____ dd / mm / yy

Signature of 3rd Party _____ Print Name _____ Date _____ dd / mm / yy

PATIENT/SDM TRANSLATOR DECLARATION

I have translated the conversation between _____
Print Name of Physician/ Healthcare Practitioner
and _____.
Patient/SDM

Signature of Translator _____ Print Name _____ Date _____ dd / mm / yy