

Patient 105  
 Name: [REDACTED] write details  
 D.O.B.: [REDACTED] Personal Information redacted by the  
 H&C No: [REDACTED] USI

Date of Clinic / Decision to list  
 Consultant WIT-59258  
 Specialty Urology

\*\*\* FOR URGENT BOOKABLE LIST \*\*\*  
 Please DO NOT list a Patient for surgery if further tests or assessments are needed

Diagnosis: RIGHT UPPER TRACT COLIC  
 Procedure: REMOVAL OF STONE & RIGHT FLEX. URETER. LITHOTRIPSY  
 Estimated Duration of Surgery: 2 HOURS  
 Additional Comments / Instructions: FOR ADMISSION TO D.H. HOSPITAL

**Urgency**  
 Please tick appropriate box

|          |                                     |
|----------|-------------------------------------|
| Red Flag |                                     |
| Urgent   | <input checked="" type="checkbox"/> |
| Routine  |                                     |
| Planned  |                                     |

**Anaesthetic Type**  
 Please tick appropriate box

|                  |                                     |
|------------------|-------------------------------------|
| General / Spinal | <input checked="" type="checkbox"/> |
| Sedation         |                                     |
| Local            |                                     |

**IF NOT suitable for day of surgery admission – please state & give reason**

**Intended Management**  
 Please tick appropriate box

|           |                                     |
|-----------|-------------------------------------|
| Day Case  |                                     |
| Inpatient | <input checked="" type="checkbox"/> |

Patients should be listed as a day case if the intention is for no overnight stay following surgery. It does not matter which ward or unit they are admitted to.

Please note, that unless indicated below, for scheduling purposes the patient will be shared across the Trust.

Please detail if the patient is required to be admitted to:

|                           |         |
|---------------------------|---------|
| Specific Site Requirement | DHH     |
| Specific Unit Requirement | Level 4 |
| Specific Consultant       |         |

Is the Patient on any Anti-Coagulation Or Anti-Platelet Therapy? No ☐ Yes ☒

If yes, please indicate if patient is on any of the medications below and the action required:

- Warfarin? ☐
- Aspirin 300mg? ☐

PLEASE TURN OVER & indicate the bleeding risk of the procedure.

Please advise whether the Patient should either:

- a. Reduce to 75mg daily 7days prior to surgery ☐
- b. Continue to take as normal ☐
- c. Shoulder arthroscopy, thyroid, parotid or parathyroid surgery – stop all aspirin 7 days prior to surgery ☐

Please advise:

- a. Patient has had stenting within the past year thus Surgeon should contact Cardiologist to advise ☐
- b. Patient should discontinue 7days prior to surgery ☐

- Dabigatran, Rivaroxaban or Apixaban? ☒ Please refer to Trust Guidance and SPC.

Latex Allergy? No ☒ Yes ☐

MRSA? No ☒ Yes ☐

Diabetic? No ☒ Yes ☐ If yes, how is the diabetes controlled? Insulin ☐ Tablet ☐ Diet ☐

A decision to add a patient to the waiting list must be discussed and countersigned by the Consultant in charge.  
 If the Consultant is not available, a decision should be made to discuss decisions at a suitable point thereafter.

|                            |            |          |
|----------------------------|------------|----------|
| Doctor's Signature         | Print Name | Date     |
| [REDACTED]                 | JOHN CHEN  | 07.06.20 |
| Countersigned (Consultant) | Date       |          |
| [REDACTED]                 |            |          |

Received from SHSCT on [REDACTED] Services Inquiry:



|               |  |                  |
|---------------|--|------------------|
| Patient Name: | Patient 104                              | Personal details |
| D.O.B.:       | Personal Information redacted by the USI |                  |
| H&C No:       |  |                  |

|                                   |              |
|-----------------------------------|--------------|
| Date of Clinic / Decision to list | WIT 11.02.20 |
| Consultant                        | ADAM O'BRIEN |
| Specialty                         | UROLOGY      |

\*\*\* FOR URGENT BOOKABLE LIST \*\*\*  
Please DO NOT list a Patient for surgery if further tests or assessments are needed

|                                     |  |
|-------------------------------------|--|
| Diagnosis:                          | RIGHT UPPER GROSS COLIC                            |
| Procedure:                          | REMOVAL OF STONE & FLEX. URETEROSCOPIC LITHOTRIPSY |
| Estimated Duration of Surgery:      | 2 HOURS  |
| Additional Comments / Instructions: | UIC OR KINGSBRIDGE OR DHH                          |

| Urgency                     |                                     |
|-----------------------------|-------------------------------------|
| Please tick appropriate box |                                     |
| Red Flag                    |                                     |
| Urgent                      | <input checked="" type="checkbox"/> |
| Routine                     |                                     |
| Planned                     |                                     |

| Anaesthetic Type            |                                     |
|-----------------------------|-------------------------------------|
| Please tick appropriate box |                                     |
| General / Spinal            | <input checked="" type="checkbox"/> |
| Sedation                    |                                     |
| Local                       |                                     |

| IF NOT suitable for day of surgery admission – please state & give reason |
|---|
|   |

| Intended Management         |                                     |
|-----------------------------|-------------------------------------|
| Please tick appropriate box |                                     |
| Day Case                    |                                     |
| Inpatient                   | <input checked="" type="checkbox"/> |

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| Please detail if the patient is required to be admitted to: |          |
|---|----------|
| Specific Site Requirement                                   | AS ABOVE |
| Specific Unit Requirement                                   |          |
| Specific Consultant   |          |

Is the Patient on any Anti-Coagulation Or Anti-Platelet Therapy? No ☒ Yes ☐

If yes, please indicate if patient is on any of the medications below and the action required:

- Warfarin? ☐
- Aspirin 300mg? ☐
- Clopidogrel or Prasugrel? ☐
- Dabigatran, Rivaroxaban or Apixaban? ☐

PLEASE TURN OVER & indicate the bleeding risk of the procedure.

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If the Consultant is not available, then arrangements should be made to discuss decisions at a suitable point thereafter.

|                            |                   |          |
|----------------------------|-------------------|----------|
| Doctor's Signature         | Print Name        | Date     |
|                            | ADAM O'BRIEN      | 07.06.20 |
| Countersigned (Consultant) | Services Inquiry. | Date     |
|                            |                   |          |