



WRHN

Waterloo Regional
Health Network

MOP	Fax 519-749-4292
Gyne Laser Fax 519-749-4292	
MDU	Fax 519-749-4335

AMBULATORY CLINIC BOOKING FORM	ver. 1.0.0
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Surname: _____ First Name: _____ Middle Name: _____
 Gender: M F DOB (yyyy/mm/dd): _____ Age: _____ Wt.: _____ kg.
 Address: _____
 City: _____ Province: _____ Country: _____ Postal Code: _____
 Home Phone: _____ Business Phone: _____
 Health Card Number: No Yes HCN: _____ HCN Prov: _____ Version: _____

Physician: _____

Allergies: _____ Latex Allergy

Diagnosis: _____

Procedure: _____

Special Instructions/ Equipment/ Comments: _____

Procedure Date (yyyy/mm/dd): _____	Procedure Time: _____
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Patient orders for this case should be written on a STANDARD HOSPITAL ORDER, signed and faxed to bookings

Physician's Statement of Informed Consent: I have explained the anticipated nature, benefits, material risks and side effects, any alternative courses of action, likely consequences of not having the above treatment, that other physicians, hospital staff or students may assist in the treatment and have responded to questions or concerns of the patient/Substitute Decision Maker.

Physician's Signature: _____	Date (yyyy/mm/dd): _____
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