



**ANAESTHESIA BOOKING FORM**

Medicare number		Reference number	
Last name		Mr / Mrs / Ms / Miss / Master / Dr / Prof	
First name		Date of Birth	
Postal address <i>(as registered with Medicare and your Health Fund)</i>			
<i>We will send communication electronically and/or via SMS where possible.</i>		<u>Email:</u>	
		<u>Mobile:</u>	
		<u>Home phone:</u>	
Person responsible for the account if not you		Address <i>(if different to yours)</i>	
Health Fund & membership number			
Veteran affairs number <i>(if applicable)</i>			
TAC claim number <i>(if applicable)</i>			
Work cover claim <i>(if applicable)</i>			
Planned date of procedure		Hospital	
If you are a diabetic patient please record your diabetic medication(s) below: ..... <i>We will contact you prior your fasting period for medication guidance.</i>			
<b>THIS SECTION TO BE FILLED IN BY YOUR PROCEDURALIST PLEASE</b>			
Your proceduralist's name Dr / Mr / Miss / Ms / Prof.....			
Planned procedure.....			
Estimated duration of procedure.....			

An estimate for services will be generated for you from this completed form. Early return of the form will assist you in receiving an estimate prior to surgery. Thank you.

Post to: 20 Drought Street Bendigo, or Fax to 03 5407 1456, or email to [reception@bendigogas.com.au](mailto:reception@bendigogas.com.au)

*Our office hours are 10am to 1pm.*

*Should you telephone out of hours, please leave a message, and we will return your call promptly.*