WESTERN DAY SURGERY BOOKING FORM

145 FURLONG ROAD
ST. ALBANS VIC 3021
T: 9366 0666
F: 9366 0777

Patient's Name:

Date of Birth: / / **Female** ☐ **Male** ☐

Address:

Telephone:

Home: Work: Mobile:

Procedure:

Proposed Date: **Time:**

Theatre Time:

Specific Requests:

Facility Fees:

Private Health Fund ☐ Self Insured ☐

Fund Name:

Membership Number:

Surgeon: **Telephone:**

CONFIRMATION OF BOOKING BY WESTERN DAY SURGERY

Procedure Date: Time:

Facility Fee: (Payable prior to Admission)

WDS Admissions Officer Signature: Date: