WELCOME

Welcome to The Centre.

We are grateful to you attending a consultation with Dr. De Silva at The Centre today.

We operate a bespoke service and please notify us if we can do anything to make your visit more pleasant.

The following pack of information is set of customized forms that include registration details, patient rights & responsibilities. If you should have any questions regarding these forms do not hesitate to ask our staff.

LONDON CENTRE FOR ADVANCED FACIAL COSMETIC & PLASTIC SURGERY

PATIENT'S REGISTRATION FORM

PATIENT INFORMATION	
Patient Name:	
Date of birth:	
Gender:	
Address:	
Email Address**:**	
Home Telephone Number:	
Mobile/ Work Telephone number:	
How do you like to be contacted: May we leave messages on your answer machine? May we contact you by post? Other?	 □ Yes □ No □ Yes □ No _____
Name of next of kin or emergency contact:	Telephone:
Do you have someone to take care of you after your surgery?	□ Yes □ No
Are you currently: □ Single □ Partner □ Engaged □ Married □ Widowed □ Divorced □ Separated	
Have you an important date coming up in the next 6-months?	
Current Profession/ Employment? □ Profession _____ □ Retired □ Family/ Young Children □ Career break	
Any special sports/ hobbies?	
Other relevant information?	
GENERAL PRACTITIONER OR PRIMARY CARE PHYSICIAN	
Physician Name: Is this your GP: □ Yes □ No	
Address:	
Telephone:	
Date of most recent Physical Examination:	
How did you hear about us:	

LONDON CENTRE FOR ADVANCED
FACIAL COSMETIC & PLASTIC SURGERY

PATIENT MEDICAL HISTORY

Procedures I would like to discuss with the doctor (Please tick):

☐Eyelid Rejuvenation/ Blepharoplasty, ☐Forehead/Brow Lift
☐Nose Re-Shaping/ Rhinoplasty
☐Facelift ☐ Necklift, Neck Liposuction
☐Volume Replacement ☐Fat Transfer
☐Chin Implant ☐Cheek Implant ☐Facial/Neck Liposuction
☐Ear Surgery/ Otoplasty/ Ear pinning/ Ear lobe reshaping
☐Lip Surgery/ Lip reduction/ Lip enlargement
☐Skin Rejuvenation: ☐Chemical Peel ☐Laser Resurfacing
☐Skin growths/moles/ Scarring/ Other

Non-Surgical Treatments
☐Botox ☐Fillers (Restylane, Juvaderm etc) ☐Other

What would you like to change about your facial appearance?

……
……
……
……

Have you ever had or used:	
Retin A (topical tretinoin)	□ Yes □ No
Chemical peels	□ Yes □ No
Microdermabrasion	□ Yes □ No
Laser, type _____	□ Yes □ No
Botox	□ Yes □ No
Restylane,	□ Yes □ No
Other Filler, etc Silicone	□ Yes □ No
Accutane	□ Yes □ No
Herpes (or cold sore) medication	□ Yes □ No
Oral contraceptives	□ Yes □ No
Other	_____

Sun Exposure/ Protection:	
Sun exposure-Past	□ Minimal □ Excessive
Sun exposure-Present	□ Minimal □ Excessive
Tanning Beds- Past	□ Minimal □ Excessive
Tanning Beds-Present	□ Minimal □ Excessive
Sunscreen	□ Never □ Occasional □ Daily
First day in Sunshine	□ Burn □ Tan □ No skin change

Do you smoke? If so how much per day?	□ Yes □ No _____

Height _____ Weight _____

LONDON CENTRE FOR ADVANCED
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PATIENT MEDICAL HISTORY	
How is your general health, any current issues?	
Past Medical Conditions:	
Past Cosmetic Procedures:	
Past Surgical Procedures/ Year:	
Family Conditions:	
Please list any current medications:	
Please list any herbal medications: (e.g. Vitamin supplements, St.John's Wort, Fish oils, garlic, ginseng)	
Any Allergies to medications: Penicillin Aspirin Codeine Elastoplast Sedatives/ Sleeping pills Latex Local Anaesthetics Other:	 □ Yes □ No □ Yes □ No □ Yes □ No □ Yes □ No □ Yes □ No □ Yes □ No □ Yes □ No _____
Do you take any of the following medications: Aspirin NSAIDs e.g.Ibuprofen Plavix Warfarin Accutane (Isotretinoin)/ (Vitamin A)	 □ Yes □ No □ Yes □ No □ Yes □ No □ Yes □ No □ Yes □ No
Women only Are you pregnant? Are you breast feeding? Are you taking the contraceptive pill?	 □ Yes □ No □ Yes □ No □ Yes □ No
Do you smoke? If so how much per day? Are you a former smoker? If yes, when did you quit smoking?	□ Yes □ No _____ □ Yes □ No _____
Do you drink alcohol? If so how much per week?	□ Yes □ No _____
Do you use recreational drugs? If so how much per week?	□ Yes □ No _____

GENERAL HEALTH			
	Yes	No	Details:
Do you suffer from: Anaemia? Sickle Cell Thalassaemia? Bruise easily? Bleeding or blood disorders? Fainting? Convulsions or Epilepsy?			If yes please explain,
Have you had any major illnesses in the past?			
Do you have a history of: Recent lift crisis e.g. divorce, Bereavement etc. Anxiety? Depression? Psychological condition? Other?			If yes, which medication are you taking and for how long?
Have you had any major operations in the past? If yes, were there problems with the anaesthetic? Previous Sedation? Previous failed Sedation? Previous General Anaesthetic? Previous Anaphylaxis?			
Do you have any frontal caps or veneers on your teeth?			

CARDIAC HEALTH			
Do you suffer from:	Yes	No	Details:
High Blood Pressure?			
Low Blood Pressure?			
Chest pains (Angina)?			
Heart Attack?			
Swelling of the ankles?			
Palpitations?			
Breathlessness on exertion?			
Have you had Rheumatic Fever?			

RESPIRATORY HEALTH			
Do you suffer from:	Yes	No	Details
Breathlessness?			
Asthma?			
Bronchitis?			
A previous blood clot in the lung or thrombosis?			
Frequent cough?			

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GASTROINTESTINAL HEALTH			
Do you suffer from:	Yes	No	Details
Ulcer/ Digestive problems?			
Jaundice?			
Liver problems?			
Problems when passing urine?			
METABOLIC HEALTH			
Do you suffer from:	Yes	No	Details
Diabetes?			
Low blood sugar?			
Arthritis?			
Muscle weakness?			
Eating disorder?			
LOCOMOTOR HEALTH			
Do you suffer from:	Yes	No	Details
Disability?			
Weakness?			
Tremors?			
OTHER			
Do you suffer from:	Yes	No	Details
Glaucoma?			
Thyroid disease?			
Hives or rashes?			
Kidney Problems?			

INFECTION CONTROL				
	Yes	No	Not App	Details
Have you been an inpatient in any healthcare facility in the last 6 months?				
Have you been diagnosed with any **infections** in the last 6 months?				
If Yes, did you take Antibiotics? Please specify:				
Have you been told you have MRSA? -If Yes, have you been swabbed for MRSA prior to this admission? -Do you have a copy of your results to show you are now clear?				
Have you ever been diagnosed with Hepatitis B? Hepatitis C? HIV?				

_____ *[Signature]* _____ *[Patient Name]* _____ *[Date]*

PATIENT'S AGREEMENT: RIGHTS & RESPONSIBILITIES

Rights

- The observance of the following guidelines will provide more effective patient care and greater satisfaction for the patient, the physician and the individuals that make up the office organization. It is in recognition of these factors that these rights are affirmed.
- The patient has the right to considerate and respectful care; cultural, psychosocial, spiritual, personal values, beliefs, and preferences will be respected. Patients with vision, speech, hearing, language and cognitive impairments have the right to effective communication.
- The patient has the right to receive from his/her physician information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent should include but not necessarily be limited to the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning medical alternative, the patient has the right to know the name of the person(s) responsible for the procedures and/or treatment as well as the person(s) responsible for their sedation and anesthesia.
- The patient has the right to every consideration of his/her privacy concerning his/her medical care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly. The patient has the right to expect that all communications and records pertaining to his/her care should be treated as confidential. Those not directly involved in his/her care must have permission of the patient to be present.
- The patient has the right to obtain from the physician complete current information concerning his/her diagnosis, treatment, and prognosis in terms the patient can be reasonably expected to understand. The patient has the right to be involved in decisions about their care, treatment and services and the patient has the right to have their pain assessed, managed, and treated as effectively as possible.
- The patient has the right, and when appropriate, the patient's family to be informed of unanticipated outcomes of care, treatment, and services that relate to sentinel or adverse reviewable events.
- The patient has the right to expect that within its capacity, this ambulatory facility must provide evaluation, service and/or referral as indicated by the urgency of the case. When medically permissible, a patient may be transferred to another facility only after he/she has received complete information and explanation concerning the needs for and alternatives to such a transfer.
- The patient has the right to obtain information as to any relationship of this facility to other health care and educational institutions insofar as his/her care is concerned. The patient has the right to obtain information as to the existence of any professional relationships among individuals, by name, which is treating him/her.
- The patient has the right to expect reasonable continuity of care. The patient has the right to expect that this facility will provide a mechanism whereby he/she is informed by his physician of the patient's continuing health care requirements following discharge.
- The patient has the right to know the mechanisms for grievance as well as suggestions.

- The patient has the right to change their choice of physician.
- The patient has the right to refuse care, treatment, and services in accordance with law and regulation.
- The patient has the right to dispute information in their medical record
- The patient has the right to examine and receive an explanation of his/her bill and to expect ethically billing practices.

Responsibilities

- The patient has the responsibility to provide the physician with the most accurate and complete information regarding present complaints, past illnesses, hospitalizations, medications, allergies and unexpected changes in the patient's condition.
- The patient will inform the physician if the are pregnant or breast feeding.
- The patient is responsible for asking questions when they do not understand what they are told or what they are expected to do.
- If the plan of care is agreed upon, the patient has the responsibility to follow the plan of care or express concerns with compliance. The patient and family are responsible for following the preoperative and post discharge care plan. The patient and family are responsible for the outcomes if the do not follow the care plan.
- In consideration for treatment and the above noted patient protection, if Patient or journalist prepares such commentary for publication including surgical techniques or other confidential material discussed during the consultation on web pages, blogs, magazines or newspapers about the Physician, the Patient exclusively assigns all Intellectual Property rights, including copyrights, to Physician for any written, pictorial, and/or electronic commentary.
- The patient is responsible to provide an adult to transport him/her home from the facility and remain with him/her for 24 hours, if required by his/her physician.
- The patient is responsible to inform his/her physician about any living will medical power of attorney, or other directive that could affect his/her care.
- The patient and family are responsible for following the practice's rules and regulations concerning patient care and conduct
- There are CCTV surveillance cameras in this facility for practice/patient safety, security & training, in accordance with General Medical Council guidelines and the Information Commissioner's Office.
- Patients and families are responsible for being considerate of the practice's staff and property.
- The patient and family are responsible for promptly meeting any financial obligation agreed to with the practice.

_____ *[Signature]* _____ *[Patient Name]* _____ *[Date]*