Physician's Assessment for Treatment / Surgery

Patient's Name: _____ **Male / Female** **Age:** _____

Doctor's Name: _____

Diagnosis: _____

_____

Details of recommended treatment / surgery: _____

_____

_____

_____

Estimated number of hours in operating theater: _____
Estimated number of hours in recovery room: _____ **or ICU:** _____

Special materials / medications / instrumentation: _____

_____

Anesthesia: _____ **Blood bank:** _____
Frozen section: _____ **Histology:** _____
Number of days hospitalization: _____ **Required stay in Israel:** _____

Fee you request for surgery: _____
Fee for your assistant if required: _____
(Fee for surgery includes pre & post surgical consultations, HMC provides anesthetist)

Pre-surgical examinations required: (Please specify in detail)
Consultant Physicians: _____
Anesthetist - pre-surgical examination: _____
Laboratory: _____
Radiology: _____
Cardiology: _____
Other: _____

_____

Post-Operative Requirements:
Consultant Physicians: _____
Physiotherapy: _____
Home-care: _____
Ambulatory treatment: _____
Other: _____

Doctor's signature: _____ **Date:** _____