

Admission Letter (General)

Name: _____
 Patient HKID/Passport No: _____
 Sex/Age: _____ DOB: _____
 Patient Contact No.: *Please fill in or* _____
 Attending Doctor: *affix out-patient label*

In-Patient Label

Admission Date: _____ **& Time** _____ **Expected Length of Stay:** _____ **day (s)**

*** *Day / Bay cases* ≤ 6 hours

Room type: Day Day Semi-private Double Day Semi-private Single Day Private Single Day Junior Suite
 Bay Standard Semi-private Double Semi-private Single Private Single Junior Suite VIP
Service Location: Dialysis Centre Endoscopy Centre Chemo Centre ICU HDU Negative Pressure Room

Inpatient		
Allergy Information:	Allergic to:	Type of Reaction:

Please **do not eat or drink** on (Date) _____ at _____ AM / PM* (Cross out the inappropriate)

Special diet: vegetarian diabetics soft diet Others, please specify: _____

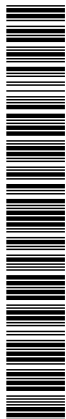
Standard Procedure Package: (Standard Bed Class only)

NO **YES (package code no.:** _____ **)** **Normal Risk** **Intermediate Risk**

Risk classification is mandatory for package (* Please refer to Risk Classification Guidelines for examples)

Risk	Definition*	AND Functional and Demographic Criteria
<input type="checkbox"/> Normal Risk	Healthy with no comorbidity or well controlled disease(s) with no end organ damage	<ul style="list-style-type: none"> No functional limitation (able to walk up 3 flights of stairs without stopping) * BMI <30 Age <85 years
<input type="checkbox"/> Intermediate Risk	Significant systemic disease under control with treatment and/or mild decompensation	<ul style="list-style-type: none"> Functional limitation (able to walk up 1-2 flights of stairs without stopping) * BMI <35 Other: _____
<input type="checkbox"/> High Risk	Potentially life-threatening systemic disease (life threatening conditions are the main criteria) where likelihood of unexpected HDU/ICU post operatively is probable	<ul style="list-style-type: none"> Severe frailty: Completely dependent for personal care, from whatever cause (physical or cognitive) BMI >= 35 Redo procedures e.g. previous abdominal surgery excluding cholecystectomy and appendectomy for intestinal surgery, or redo joint replacement Other: _____

Significant Medical History		Mental Health Issues:
Current Medication		
Provisional Diagnosis		
Investigations/ Treatments	Laboratory Tests: Radiology Tests: Others:	



Admission Booking with OT & Procedure
Contact no.: OT: 3153 9288 / 3153 9289
* Please fax admission letter to 3903 3407 (For OT booking only)
Contact no.: Endoscopy: 31539130, CVL: 3153 9223
* Please fax admission letter to 3903 3490 (For Endoscopy & CVL booking)
Admission Booking without OT
Bed Booking: 3153 9010 Fax no.: 3903 3490

Admission Letter (General)

Name: Patient HKID/Passport No: Sex/Age: DOB: Patient Contact No.: <i>Please fill in or</i> Attending Doctor: <i>affix out-patient label</i>	<h1 style="color: #ccc;">In-Patient Label</h1>
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Prescription / Supplement	Prescription: Prescription endorsement for the use of the following intravenous fluid for reconstitution and dilution of all prescribed medication(s) for this patient for use within the hospital, with reference to <i>GHK Injectable Drug Reconstitution and Dilution Table</i> . IV 10mL Water for Injection PRN, IV 10mL 0.9% Sodium Chloride PRN, IV 100mL, 250mL 0.9% Sodium Chloride PRN, IV 100mL, 250mL 5% Dextrose PRN
Planned Procedure / Operations	Date: Time: Surgeon: Anaesthetist: Operation Name: Expected Surgical Procedure Time: Anaesthesia Type: <input type="checkbox"/> LA <input type="checkbox"/> GA <input type="checkbox"/> MAC <input type="checkbox"/> SA <input type="checkbox"/> IV Sedation <input type="checkbox"/> Others: _____ Special equipment/consumable request: (Harmonic Scapel, implants, etc)

Patient's Insurance Coverage: <i>(Please specify insurance company & plan where applicable)</i>	
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Estimated Doctor's Fees 預算醫生費用 (To be completed by Attending / Admitting Doctor 由主診/轉介醫生填寫)		
Daily Doctor's Visit Fee 每日醫生巡房費:	\$	X _____ day(s) 日
Surgical Operation Fee 手術費:	\$	
Anaesthetist's Fee 麻醉科醫生費:	\$	
Other Specialists' Consultation Fee (Please Specify) 其他專科醫生診療費用 (請註明):	\$	
Other Items and Charges 其他項目及收費:	\$	
Total Doctor's Fee 醫生費總計 (Hospital Charges are billed separately 醫院收費另計)	\$	

I have explained to the patient / next-of-kin / authorised person details of the above estimated charges and have sought his / her agreement.
 本人已向病人 / 親屬 / 獲授權人士解釋上述預算費用，並徵得其同意。

Signature of Doctor 醫生簽署	Name & Contact Information of Doctor 醫生姓名	Doctor Reg. No.: 註冊編號	Date 日期
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DISCLAIMER: 免責聲明

I note that the quoted doctor's fee does not include hospital charges. I understand that this budget estimate is not legally binding and is for reference only. Additional charges incurred from complications and from other diseases diagnosed after admission are not covered. I agree that final payments are subject to charges incurred from treatment, procedures and services performed and should be made in accordance with hospital invoice.

本人知悉醫生預算之費用並不包括醫院收費。本人知悉服務預算費用並無法律效力，僅為參考，並不包括因併發症以及入院後發現的其他疾病所產生的額外費用。本人同意最終收費視乎病人實際接受的治療、程序及服務而定，並以醫院帳單所列為準。

Signature of Patient / Next-of-kin / Authorised Person 病人 / 親屬 / 獲授權人士簽署 (Age 18 or above 18 歲或以上)	Name of Patient / Next-of-kin / Authorised Person 病人 / 親屬 / 獲授權人士姓名	Relationship 關係	Date 日期
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Please bring along the completed admission letter & consent forms for surgical procedure. 住院時請攜帶此入院信及手術同意書。

Remarks / Request: _____

