Gleneagles Hospital
HONG KONG
港怡醫院

Admission Booking with OT & Procedure / DSA Procedure (Radiology)
Contact no.: **OT:** 3153 9288 / 3153 9289 **DSA:** 3153 9636
Contact no.: **Endoscopy:** 31539130 **CVL:** 3153 9223
**** Please fax admission letter to 3903 3407 (For OT booking only)***
**** Please fax admission letter to 3903 3490 (For Endoscopy & CVL booking)***
**** Please fax admission letter to 3903 3492 & 3903 3490(For DSA booking only)***
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.:
Attending Doctor:

For Clinic Use
Please fill in or 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 ☐ Radiology (DSA)

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
☐ Normal Risk	Healthy with no comorbidity or well controlled disease(s) with no end organ damage	• No functional limitation (able to walk up 3 flights of stairs without stopping) * • BMI <30 • Age <85 years
☐ Intermediate Risk	Significant systemic disease under control with treatment and/or mild decompensation	• Functional limitation (able to walk up 1-2 flights of stairs without stopping) * • BMI <35 • Other:_____
☐ High Risk	Potentially life-threatening systemic disease (life threatening conditions are the main criteria) where likelihood of unexpected HDU/ICU post operatively is probable	• 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:**	

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Prescription/Supplement 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 GHK Injectable Drug Reconstitution and Dilution Table: 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	**Name of Drug**	**Dose**	**Route**	**Frequency & Duration**

Planned Procedure / Operations

Date: Time: Surgeon: Anaesthetist:

Operation Name:

Expected Surgical Procedure Time:

Anaesthesia Type: ☐ LA ☐ GA ☐ MAC ☐ SA ☐ IV Sedation ☐ Others: _____

Special equipment/consumable request:
(Harmonic Scapel, implants, etc)

Patient's Insurance Coverage:
(Please specify insurance company & plan where applicable)

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

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

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:_____