Gleneagles Hospital
HONG KONG
港怡醫院

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.:
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)

Room type: ☐ Day (6 hours only: ☐ Standard ☐ Semi-private Double ☐ Semi-private Single ☐ Private Single)
☐ Standard ☐ Semi-private Double ☐ Semi-private Single ☐ Private Single ☐ Junior Suite
☐ VIP Suite ☐ Others: (☐ Dialysis / ☐ Endo Bay / ☐ ICU / ☐ HDU / ☐ Acute Care / ☐ Isolation)

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:**
	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
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 總計	$	

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 understand that this budget estimate is not legally binding and is for reference only. Additional charges incurred from complications and from 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.
本人知悉套餐的使用條款及延長住院所收取的額外費用，並同意最終應繳費用以醫院賬單所列為準。

Signature of Patient / Next-of-kin / Authorized Person 病人 / 親屬 / 獲授權人士簽署 (Age 18 or above 十八歲或以上)	Name of Patient / Next-of-kin / Authorized 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:_____

1 Nam Fung Path, Wong Chuk Hang, Hong Kong (852) 3153 9000