Gleneagles 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 (Behavioral Health)

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)**

Inpatient

Allergy Information:	*Allergic to:*	*Type of Reaction:*

Standard procedure package:

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

☐ NO Room type: ☐ Semi-private Double ☐ Private Single

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

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

Significant Medical History				
Significant Mental History (e.g. self-harm, suicide or violence)				
Reason of Admission				
Provisional Diagnosis				
Current Medication				
Current Condition: Risk Factors		**NO**	**YES**	**Details**
	Self-harm			
	Suicidal ideation			
	Harm to others			
	Substance / alcohol misuse			

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Planned Investigations/ Treatments	**Anticipated Laboratory Tests:** Blood / Body Fluids / Tissues *(Please circle revelant test type and specify body part. Please indicate whether it is a pre/post-operation test.)* **Required Radiology Tests:** CT / PET-CT / MRI / X-Ray *(Please circle revelant test type and specify body part. Please indicate whether it is a pre/post-operation test.)* **Other Required Tests** (e.g. ECG, lung function test)**:** *(Please specify whether test is required pre/post-operation)*
Planned Prescription / Supplement (e.g. medication, diet or restraint)	**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
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)

Please bring along the completed consent forms for surgical procedure.

Remarks / Requests: _____

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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