

# Admission Letter (Behavioral Health)

Name: \_\_\_\_\_

Patient HKID/Passport No: \_\_\_\_\_

Sex/Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Contact No.: *Please fill in or* \_\_\_\_\_

Attending Doctor: \_\_\_\_\_  
*affix out-patient label*

*In-Patient Label*

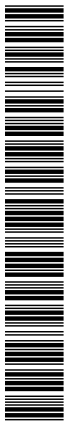
**Admission Date:** \_\_\_\_\_ **& Time** \_\_\_\_\_ **Expected Length of Stay:** \_\_\_\_\_ **day (s)**

Inpatient		
Allergy Information:	<i>Allergic to:</i>	<i>Type of Reaction:</i>

Standard procedure package:

- YES (package code no.: \_\_\_\_\_)   
  Normal Risk   
  Intermediate Risk  
 NO   
 Room type:  
  Day-Semi-private Double  
  Day-Semi-private Single  
  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: \_\_\_\_\_

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



## Admission Letter (Behavioral Health)

Name:

Patient HKID/Passport No:

Sex/Age:                      DOB:

Patient Contact No.: *Please fill in or*Attending Doctor: *affix out-patient label**For Clinic Use**In-Patient Label*

Planned Investigations/ Treatments	<b>Anticipated Laboratory Tests:</b> Blood / Body Fluids / Tissues <i>(Please circle relevant test type and specify body part. Please indicate whether it is a pre/post-operation test.)</i>
	<b>Required Radiology Tests:</b> CT / PET-CT / MRI / X-Ray <i>(Please circle relevant test type and specify body part. Please indicate whether it is a pre/post-operation test.)</i>
	<b>Other Required Tests</b> (e.g. ECG, lung function test): <i>(Please specify whether test is required pre/post-operation)</i>
Planned Prescription / Supplement (e.g. medication, diet or restraint)	<b>Prescription/Supplement:</b>
	Prescription endorsement for the use of the following intravenous fluid for <b>reconstitution and dilution</b> 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)

**Please bring along the completed consent forms for surgical procedure.**

Remarks / Requests: \_\_\_\_\_



## Admission Letter (Behavioral Health)

Name: \_\_\_\_\_

Patient HKID/Passport No: \_\_\_\_\_

Sex/Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Contact No.: *Please fill in or* \_\_\_\_\_

Attending Doctor: \_\_\_\_\_  
*affix out-patient label*

In-Patient Label

<b>Patient's Insurance Coverage:</b> <i>(Please specify insurance company &amp; plan where applicable)</i>		
<b>Estimated Doctor's Fees 預算醫生費用</b> <i>(To be completed by Attending / Admitting Doctor 由主診/轉介醫生填寫)</i>		
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	\$ _____	
<b>Total 總計</b>	\$ _____	

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
--	---	--------------------	------------