Gleneagles HONG KONG 港怡醫院

Patient Name:	
DOB:	Sex:
HKID / Passport:	
Patient's Contact:	
Or Patient Label	

Admission Letter (Maternity)

For booking of Elective C/S, please call Operation Theater Tel: 3153 9288 and Fax to: 3903 3407
For booking of Induction of labour: please call Labour Ward Tel: 3153 9277 and Fax to: 39033412

Please bring all Antenatal blood report on admission
Date and Time of Admission: _____

Category of hospital bed required ☐ Family Suite ☐ Private Single ☐ Semi-Private Single ☐ Standard

Gravida & Parity: _____ Maturity: _____ EDC: _____

Past Obstetric/Medical History:

_____

_____

Allergy Information	☐ NKDA ☐ Allergic to _____ Type of Reaction_____

Preparation for Vaginal Delivery/ Induction

☐ Fleet enema p.r.n.

☐ Shave pubic hair (☐ half shave / ☐ whole shave / ☐ no shave)

☐ Pethidine _____mg IMI ☐ Q4H / ☐ Q6H p.r.n.

☐ Epidural Analgesia. Anaesthetist: _____

☐ PGE_2 intra-vaginally. Dosage: _____

☐ Syntocinon Infusion: Start at _____units into _____☐ 500 / ☐ 1000 ml at _____ml/hr

☐ Cord Blood Collection ☐ Others:_____

Preparation for LSCS on _____ at _____under ☐ GA / ☐ SA

Indication for LSCS: _____ Anaesthetist: _____

☐ Fleet enema p.r.n. ☐ Full Abdominal & Pubic shaving

☐ Foley's Catheter to BSB /in OT ☐ Cord Blood Collection ☐ Others:
_____

Postnatal Treatment:

☐ BF ☐ AF ☐ Infant formula_____

☐ Paediatrician_____

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 Doctor: _____ Dr Code: _____

Signature of Doctor: _____ Date: _____

Patient Name:

DOB: Sex:

HKID / Passport:

Patient's Contact:

Or Patient Label

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Admission Letter (Maternity)

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	$	

Signature of Doctor: **Name & Contact Information of Doctor :** **Doctor Reg. No.:** **Date:**

_____ _____ _____ _____

In BLOCK letter M00001

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 of Doctor
醫生姓名

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