

ZADG_MAD02_P

(V1)
Sep. 2011



Admission Letter
Fax No.: 2895 2956

Name: _____

Patient HKID/Passport No.: _____

Sex/Age: _____

Date of Birth: _____

Patient Contact No.: _____ *Please fill in / affix patient's label*

Page No:

01	02	03	04	05	06	07	08	09
+10	+20	+30	+40	+50	+60	+70	+80	+90

To: Registration Office, St. Paul's Hospital

Date of Admission: _____

Time of Admission: _____

Category of hospital bed required *(Please tick as appropriate):*

<u>Inpatient</u>	<u>Day Case</u>
<input type="checkbox"/> Private <input type="checkbox"/> Private room required for Nebulizer	<input type="checkbox"/> Private <input type="checkbox"/> General
<input type="checkbox"/> General <input type="checkbox"/> Semi-private room <input type="checkbox"/> Isolation room	<input type="checkbox"/> Private <input type="checkbox"/> General
Will the patient be using CPAP / BiPAP machine? <i>(Mandatory Field)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Will the patient be performing Sleep Study with CPAP Titration? <i>(Mandatory Field)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No

Allergy Information:	<i>Allergic to:</i> _____	<i>Type of reaction:</i> _____
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Provisional Diagnosis / Clinical findings: _____

Investigations: _____

Treatment: _____

Medication: _____

Operation: _____

Anaesthetist: _____

Date / Time: _____

Name of Doctor: _____ Dr. Code: () Signature of Doctor: _____
(in block letters or clinic chop)

Date: _____