

ZADM_MAD01_P

(V1)
Sep. 2011



**Admission Letter
(Maternity)
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):

- Private Semi-private room General

Allergy Information:	<i>Allergic to:</i>	<i>Type of reaction:</i>
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Gravida: _____

Para: _____

EDC: _____

Past Obstetric / Medical History: _____

A/N Blood results: (Copy of the original report MUST be attached)

Antenatal Treatment :

CORD BLOOD COLLECTION

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 Anaesthesia, Anaesthetist : _____
 PGE2 intra-vaginally

Syntocinon Infusion: Start at _____ units into _____ 500/1000ml at _____ Drops /min _____

Others: _____

Preparation for LSCS on _____ at _____ GA / SA

Indication: _____ Anaesthetist: _____

- Fleet enema p.r.n. Full Abdominal & Pubic shaving Foley's Catheter* to B.S.B. / in O.T.

Postnatal Treatment :

- BF AF Infant formula _____
 Paed. Doctor : _____
 Others : _____

Name of Doctor: _____ Dr. Code: (_____) Signature of Doctor: _____

(in block letters or clinic chop)

Date: _____

* Delete as appropriate