

Patient Information *(stick Patient Label upon admission)*

SPHF-AHB-003

Patient Name: _____

Sex: _____ Age: _____

Patient HKID / Passport No.: _____

Patient Contact no.: _____

Date of Admission: _____

Estimated Admission Time: _____ a.m. / p.m.

**St. Paul's Hospital**

聖保祿醫院

Admission Letter**Fax No. : 2895 2956****To: Admission Office, St. Paul's Hospital** **Date:** _____**Category of hospital bed required** *(Please tick as appropriate):***Inpatient** Private room General ward Semi-private room Isolation room**Day Case** Bed required Bed not required**Patient Details**

Allergy Information: <i>(if applicable)</i>	<i>Allergic to:</i>	<i>Type of reaction:</i>
---	---------------------	--------------------------

Provisional Diagnosis / Clinical findings:**Investigations:****Treatment:****Operation:***Date / Time:**Anaesthetist:***Signature of Doctor:** _____**Name of Doctor :** _____**Doctor Code :** _____*(in block letters or clinic chop)*