聖保祿醫院
St. Paul's Hospital

ZADG_MAD02_P | (V8) Feb 2023

Admission Letter

Booking: 2830 3700 / 2830 3900　Enquiry: 2830 8800　Fax No.: 2895 2956

Page No:

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

For Clinic Use	For In-patient Use
Visit No.: Dept.:	Visit No.: Dept.:
Name: Sex/Age:	Name: Sex/Age:
Doc. No.: Adm. Date:	Doc. No.: Adm. Date:
Attn. Dr.:	Attn. Dr.:
Patient No.: PN	Patient No.: PN
Please fill in / affix patient's label	*Please fill in / affix patient's label*

To: Admission Department

Admission: Date ______________ & Time ______________

Expected Length of Stay: ______________

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

Inpatient

☐ Premium Private Suite	☐ Private	☐ General	☐ Cancer Fund
☐ Private room required for Nebulizer	☐ Semi-private room	☐ Isolation room	☐ Day Case

Will the patient be using CPAP / BiPAP machine? *(Mandatory Field)* ☐ Yes ☐ No

Will the patient be performing Sleep Study with CPAP Titration? *(Mandatory Field)* ☐ Yes ☐ No

Please bring along the completed consent form for surgical procedure.

Allergy Information:	☐ *None Known* ☐ *Allergic to:*______________________	*Type of Reaction:* ______________________

Provisional Diagnosis / Clinical Findings:

Investigations:

Imaging Investigations:
☐ CT ☐ MR ☐ US ☐ PET-CT
☐ MMG ☐ Fluoroscopy ☐ IR-Procedure
Date/Time: ______________________
Exam: ______________________
Status: ☐ Booked / ☐ For booking
Remarks: Please attach with imaging order form

Treatment:

Vital Sign: q ________ h

Diet: ☐ **Regular** ☐ **Low Na** ☐ **Diabetic**
☐ **Others** ______________________

Medication:

Operation:

Date / Time:　　*Anaesthestist:*

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

Date: ______________________