聖保祿醫院 St. Paul's Hospital

ZADM_MAD01_P	(V5) Mar 2020	

Admission Letter (Maternity)

Booking: 2830 3959 **Enquiry: 2830 3755**
Fax No.: 2837 5221

Page No:

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+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, 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:	☐ *None Known* ☐ *Allergic to:* ____________________	*Type of reaction:* ____________________

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*