聖保祿醫院
St. Paul's Hospital

ZADG_MAD02_P | (V8) Feb 2023

Admission Letter

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

Page No:

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

Visit No.: Dept.:
Name: Sex/Age:
Doc. No.: Adm. Date:
Attn. Dr.:
Patient No.: PN

For Clinic Use
Please fill in / affix patient's label

Visit No.: Dept.:
Name: Sex/Age:
Doc. No.: Adm. Date:
Attn. Dr.:
Patient No.: PN

For In-patient Use
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: _____ **Dr. Code: (** **)** **Signature of Doctor:** _____
(in block letters or clinic chop)
Date: _____