Canossa HOSPITAL (CARITAS) 嘉諾撒醫院

Name of Patient: _____

HKID No.:_____ M/F Age: _____ DOB: _____

Dr. _____ Date of Admission: _____

Bed/Patient No.: _____/_____

ADMISSION LETTER

Date & Time of Admission: _____ AM /PM Room category: ☐ Private ☐ Semi-private ☐ General Ward

☐ Surgical ☐ Medical ☐ General Ward ☐ Paediatric

☐ Daybed : ☐ Private ☐ Semi-private ☐ General Ward ☐ Day Case (outpatient)

Patient's Name: _____ Date of Birth: _____

Sex: F / M HK ID /Passport No. _____ Tel/Mobile: _____

Provisional Diagnosis: _____

Attending Doctor: _____ (Please print) Tel/Mobile: _____

Past Medical History: ☐ Asthma ☐ DM ☐ Hypertension ☐ Coronary Heart Disease

_____

_____

_____

_____

Allergy: _____

Current Medication: ☐ Anti- Hypertensive drugs _____

☐ DM Drugs _____

☐ NSAID _____ ☐ Anti-coagulants _____

☐ Others _____

Risks: ☐ Bleeding ☐ Fall ☐ Pressure Sore

☐ Others _____

Advance Directive: ☐ No ☐ Yes → bring a copy and give it to ward nurse

Doctor's Order:

_____ _____

_____ _____

_____ _____

_____ _____

Acknowledgement of "type & screen" for major procedure Doctor signature: _____

Type & screen: ☐ No ☐ Yes

Operation/Procedure/Endoscopy _____

OT date & time _____ Anaesthesia: _____

Anaesthetist: _____ (Please print) Tel/Mobile: _____

Patient's Insurance Coverage (Please specifies insurance company & plan where applicable):

_____

Estimated Doctor's Fees 預算醫生費用 (To be completed by doctor 由醫生填寫)		
Daily Doctor's Round Fee 每日醫生巡房費:	$	X _____day(s) 日
Surgical Fee 手術費:	$	
Anaesthetist's Fee 麻醉科醫生費:	$	
Other Specialists' Consultation Fee (Please Specify) 其他專科醫生診療費用 (請註明):	$	
Other Items and Charges 其他項目及收費:	$	
Total 總計	$	

I have explained to the patient / next-of-kin / authorized person details of the above estimated charges and have sought his / her agreement. 本人已向病人 / 親屬 / 獲授權人士解釋上述預算費用，並徵得其同意。

_____ _____

Name of Doctor 醫生姓名 Signature of Doctor 醫生簽署

_____

日期 Date

DISCLAIMER 免責聲明

I understand that this budget estimate is not legally binding and is for reference only. Additional charges incurred from complications and from disease diagnosed after admission are not covered. I agree that final payments are subject to charges incurred from treatment, procedures and services performed and should be made in accordance with hospital invoice.

本人知悉服務預算費用並無法律效力，僅為參考，並不包括因併發症以及入院後發現的疾病所產生的額外費用。本人同意最終收費視乎病人實際接受的治療、程序及服務而定，並以醫院帳單所列為準。

_____ _____

Name of patient / next of kin / authorized person 病人 / 親屬 / 獲授權人士姓名

Signature of Patient / Next-of-kin / authorized person 病人 / 親屬 / 獲授權人士簽署

_____ _____

Relationship 關係 Date 日期

******* Please remind patient to bring ID card/ Birth Certificate/Passport & Deposit *******

請通知病者入院時需攜帶身份証件/出生証明/護照及按金