

Name of Patient: _____
 HKID No.: _____ M/F Age: _____ DOB: _____
 Dr. _____ Date of Admission: _____
 Bed/Patient No.: _____ / _____

ADMISSION LETTER MATERNITY UNIT

Date & Time of Admission: _____ AM / PM

Patient's Name: _____ Date of Birth: _____

Resident / non-resident HK ID / Travel document no. _____ Tel/Mobile: _____

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

Reason of admission: _____

History of pregnancy: Gravid _____ Para _____
 LMP _____ EDC _____
 Date of 1st U/S _____ Findings _____ weeks

Antenatal complications (risks): Cardiac Disease Respiratory Disease Renal Disease
 Liver Disease Thyroid Disease Psychiatric Disease Haematological Disease
 Immunological Disease Surgical Disease

Others _____

Allergy: _____

Current Medication: _____

Doctor's Order: _____

Elective C/S Anaesthesia: _____ OT date & time _____

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

Patient's Insurance Coverage (Please specify insurance company & plan wherever 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證件/出生證明/護照及按金