Approval and Referral Form

Company 公司名稱	HIP HING CONSTRUCTION CO LTD		
Patient Name 病人姓名			
Date of Injury 受傷日期		Area of Injury 受傷部位	
Diagnosis 診斷			

Reasons for Referral 轉介原因

Approval and Referral for (Please tick the appropriate box below)
批准及轉介下列專科治療(請選擇以下合適項目)

☐Specialist 專科醫生[1] ☐X-ray ≥ HK$600 per test 放射治療 ☐Laboratory Tests 化驗測試 ☐Physiotherapy 物理治療[1] ☐Occupational Therapy 職業治療[1] ☐Others 其他 e.g, MRI and CT scan[1]	Specialty: _____ Type: _____ Type: _____ No. of Treatments: _____ No. of Treatments: _____ Type: _____

Please complete this Report clearly, and fax to 3105-1827 (TRM) within 24 hours.

_____ _____

Chop and Doctor Name in Block Letter
Signature of Doctor in–charge
醫生蓋章及簽署:

Date 日期:

For emergency case, the attending doctor has authority to proceed the treatments without seeking prior approval.

[1]To be arranged by Hip Hing