Patient Information *(stick Patient Label upon admission)* Patient Name: Sex: Age: Patient Contact no.: Date of Admission: Estimated Admission Time: a.m. / p.m.	SPHF-AHB-002 聖保祿醫院 **St. Paul's Hospital** **Admission Letter** Fax: No.: 2895 2956

To: Admission Office, St. Paul's Hospital Date: _____

Category of hospital bed required *(Please tick as appropriate):*

Inpatient

- ☐ Private room
- ☐ Semi-private room
- ☐ General ward
- ☐ Isolation room

Day Case

- ☐ Bed required
- ☐ Bed not required

Patient Details

Allergy Information: **(if applicable)**	***Allergic to:***	***Type of reaction:***

Provisional Diagnosis / clinical findings:

Investigations:

Treatment:

Operation:

Date / Time:

Anaesthestist:

Signature of Doctor: _____ **Name of Doctor:** _____

Doctor Code: _____

(in block letters or clinic chop)