仁安醫院
UNION HOSPITAL

Admission Arrangement, Pre-admission Assessment & Instruction for Surgical Procedure

Please Use ID Label or Block Print			
SURNAME			UNIQUE RECORD NO.
GIVEN NAME			CHINESE NAME
SEX	AGE	WARD	ADMITTED DATE & TIME
ATTN. DR.: CON. DR.:			

1. 客人注意事項 Instruction to Client

1.1 診斷 / 主訴 / 入院原因：
Diagnosis / Chief Complaint / Reason for Admission: _____

1.2 請於_____年_____月_____日 *(上午/下午) _____時到達醫院大樓地下入院部辦理入院手續
(請於手術前**三小時或以上**(如屬剖腹分娩則提前至**四小時或以上**)入院，以便辦理入院手續及進行手術前預備工作。)
Please arrive at the Admission Office on G/F, Main Hospital Building for registration on ____/____/____at _____*(am/pm)
(Please arrive at the hospital **3 hours or more** before the scheduled operation time (**4 hours or more** in case of Caesarean Section) for registration and pre-operative preparation)

1.3 手術日期及時間：_____年_____月_____日 *(上午/下午) _____時
Operation Date and Time: _____/_____/_____ at _____ *(am/pm)

1.4 請於手術前六小時，即 *上午/下午/午夜_____時後，**不要** 進食和飲水
Please **DO NOT** eat or drink 6 hours before operation (i.e. after_____ *am / pm / 12mn)

2. 溫馨提示 Warm Reminder

☐ 已向客人提供「NUA-392c/sc入院前提示」作參考
☐ Provide "NUA-392e Information for Clients Before Admission" to client for reference

3. 選擇房間類別

☐ 標準房（四至十四人房） ☐ 半私家房 ☐ 私家房(房租 $ _____) ☐ 育嬰室
本院將盡量按客人意願安排房間，但最終安排要按客人入院時本院的房間供應而定。若屆時客人選擇的房間類別已滿，本院將會安排客人入住其他類別的房間，並按客人所入住房間類別收取費用（私家房除外）。

Preferred Room Type

☐ Standard Room (4-14 Bedded) ☐ Semi-private Room ☐ Private Room (Room Charges $ _____) ☐ Nursery
Union Hospital will do our utmost to arrange the room according to the client's choice, but the final arrangement will depend on the availability of rooms upon admission. If the selected room class is not available, client will be assigned to alternative class and be charged with the room class admitted (except private room).

4. Pre-admission Screening (Fill out by nursing staff / doctor)

Completed Form NUA-428 to conduct : Active MRSA Screening Programme Assessment	☐ No ☐ Yes	Please refer to Infection Control Manual – Section 11.2.2 "Active MRSA Surveillance Programme for patient" & proceed to NUA-428 Active MRSA Screening Programme Assessment
History of Psychiatric Illness	☐ No ☐ Yes	If "Yes", please refer to GNWG(Psychiatric)(1) "Guideline on screening of Admission of Client with Psychiatric History" and proceed to NUA-306 Zung Self-Rating Depression Scale
History of Pulmonary Tuberculosis	☐ No ☐ Yes	If "Yes", please refer to Infection Control Manual - Section 11.4.1 "Screening and Handling of Suspected / Confirmed Pulmonary TB case" & fill in NUA-371 if booking of surgery is required
Creutzfeldt – Jakob Disease Risk Assessment	☐ N/A ☐ Yes ☐ No	If "Yes", please refer to Infection Control Manual – Section 11.8 "Transmissible Spongiform Encephalopathies (TSEs) and GNWG (Infection Control) (6) "Workflow of doing the assessment to identify patient with or at increased risk of Creutzfeldt – Jakob Disease & fill in ICC-032 Assessment to identify patient with, or at increased risk of Creutzfeldt – Jakob Disease
Special cultural need (e.g. translator, diet etc.)	☐ No ☐ Yes	_____

*客人 / 家屬簽署確認
Acknowledged by *Client / Next of kin: _____ (_____)
關係 Relationship

Completed by

_____ ☐☐☐☐ _____ _____
醫生/職員簽署及編號 Doctor/Staff Signature & No. 職級 Rank 日期 Date

備註 Remarks: * 請刪除不適用之項目 Please delete inappropriate item ☐ 請在合適的方格加上✓號 Please ✓ if applicable

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Admission Arrangement, Pre-admission Assessment & Instruction for Surgical Procedure (Continued)

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5. Pre-admission Assessment and Instruction (Fill out by doctor)

5.1 Instructions after Admission:

5.2 **Medical Problems:**

- ☐ No
- ☐ Yes
  - ☐ Hypertension
  - ☐ Diabetes Mellitus (DM)
  - ☐ Cardiovascular Accident (CVA)
  - ☐ Ischaemic Heart Disease (IHD)
  - ☐ * Asthma / Chronic Obstructive Airway Disease (COAD)
  - ☐ Infectious Disease
  - ☐ Others

5.3 **Allergy History:**

- ☐ No
- ☐ Yes
  - ☐ Drug
  - ☐ Refer to CMP
  - ☐ Others

5.4 **Significant Past Operations:**

- ☐ No ☐ Yes, details

5.5 **Problems with Anaesthetic:**

- ☐ No ☐ Yes, details

5.6 **Current Medications:**

- ☐ No
- ☐ Yes
  - ☐ Anti-hypertensive Drug
  - ☐ * Oral Hypoglycaemic Agent / Insulin
  - ☐ * Aspirin / Anti-platelet Agent
  - ☐ Warfarin
  - ☐ Using of puffer (e.g. Ventolin)
  - ☐ * Prednisone / Cortisone / Other Steroids
  - ☐ Eye Drug
  - ☐ Others

5.7 **Activities / Exercise Tolerance:**

- ☐ Unlimited
- ☐ Limited to _____ FOS

Doctor's Signature	Name in BLOCK Letter	Code No.	Date

Remarks: ☐ Please ✓ if applicable * Please delete inappropriate item