Office Use Only 只供有關部門填寫
Application No. : [ ]
To : Dept of Date issue :
Pls complete and return to HIRD before________
☐ **Medical Report** ☐ **Attached Form** ☐ **SL Cert**
☐ **Others**________ Pt will fu OPD on

醫療報告及病人資料申請表格
MEDICAL REPORT / PATIENT'S INFORMATION APPLICATION FORM

(Please read the "Notes of Application for Medical Report / Patient's Information" before completing this form)
Except with the consent of the individual concerned, the personal data collected in this Form will be used for the purpose of processing this application and other directly related purposes only.
(在填寫本表格前請先參閱"申請醫療報告/ 病人資料須知")
除獲有關個人的同意外，本表格收集的個人資料只可用於處理此項申請及其他與之直接有關的目的。

1. PARTICULARS OF PATIENT 病人個人資料

(a) **Name** 姓名: **(English** 英文) ________________ **(Chinese** 中文) ________________

(b) **Sex** 性別: ☐ **Male** 男 ☐ **Female** 女 **Age** 年齡: ________ **Date of Birth** 出生日期: ________

(c) **HKID Card No.** 香港身份證號碼: ________ **OR** 或 **Passport No.** 護照號碼: ________

(d) **Address** 地址: ________________

(e) **Daytime Telephone No.** 電話號碼 **(**日間**):** ________ **Other Contact No.** 其他聯絡電話號碼**:** ________

2. NATURE OF REQUEST 申請項目 (PLEASE CHOOSE ONE ONLY 只可選擇其中一項)

☐ **Medical Report** 醫療報告
☐ **Sick Leave Certificate** 病假證明書 **From** 由 ________ **To** 至 ________
☐ **Insurance Claims Form** 保險表格
☐ **Attendance Certificate** 到診證明書 **From** 由 ________ **To** 至 ________
☐ **MAF (** 社會福利署表格**)**
☐ **Discharge Slip (Patient's Copy)** 出院紙
☐ **Attendance Record** 到診記錄
☐ **Application for Reimbursement / Direct payment of Medical Expenses (except drugs provided by the Hospital Authority)**
申請發還 / 直接支付醫療費用 **(**由醫院管理局提供的藥物的費用除外**)**
☐ **Certificate of a Person's Permanent Unfitness for a Particular Kind of Work** 成員永久不適合執行特定種類工作證明書
☐ **Certification of Disability Type for Registration Card for People with Disabilities** 殘疾人士登記證- 傷殘類別證明書**(CRR4)**
☐ **Others** 其他**:** ________________

3. HOSPITALIZATION / FOLLOW-UP RECORD 住院 / 覆診記錄

(Note : For doctors' reference only 請注意 **:** 以下要求只供醫生作參考用途**)**

(a) **Specialty** 專科部門 **:** ☐ **A&E** 急症 ☐ **ORT** 骨科 ☐ **MED** 內科 ☐ **SUR** 外科 ☐ **PSY** 精神科 ☐ **Others** 其他**:** ________

(b) **Request Period** 申請期間 **From** 由 ________________ **To** 至 ________________

4. REASON FOR APPLICATION 申請原因

(Note : For doctors' reference only 請注意 **:** 以下要求只供醫生作參考用途**)**

☐ **Insurance claim** 申索保險賠償
(☐ **Claim Form Attached** 附上保險表格 **)**
(If doctor has completed the claim form, no medical report will be issued.)
(如醫生已填寫附上的保險表格，則不會另外附上一份醫療報告。**)**

☐ **Legal proceedings (please specify in details)** 法律申訴程序**(**請列明詳情**)** ________________

☐ **Employee compensation claims** 申索工傷賠償
☐ **Immigration / Visa Application** 申請移民 / 簽證
☐ **Support of application for family reunion** 協助申請家人來港團聚
☐ **Clinical Follow-up** 醫療參考
☐ **Supplementary medical report (Please attach the previous medical report for reference)**
跟進一個已發出的醫療報告 **(**請附上以前的醫療報告以作參考**)**
Please specify items to be included
請註明跟進之事項 ________________

____

☐ **Others - Please Specify** 其他 **–** 請註明 ________________

(Please ✓ in the appropriate box – 請在適當方格填上 ✓ 號**)** **P.T.O.** 請轉下頁 **(11.2021)**

5. PARTICULARS OF APPLICANT 申請人資料

(To be completed if the applicant is a person other than the patient 如申請人非病人本身, 則須填寫此部份。**)**

(a) **Name** 姓名**: (English** 英文**)** ______________________ **(Chinese** 中文**)** ______________

(b) **Sex** 性別**:** ☐ **Male** 男 ☐ **Female** 女 **HKID Card No.** 香港身份證號碼**:** ______________

(c) **Address** 地址: **(I agree the hospital to send the medical report / patient's information to the following address by "Registered Post"**本人同意院方將醫療報告 / 病人資料以掛號形式寄往下述地址**)**

____

(d) **Relationship with patient** 與病人關係**:** ______________________ **Tel. No.** 電話號碼**:** ______________

 # Please produce the original or provide a true copy of the applicant's identity document.
請出示申請人身份證明文件或提交真確副本。

Applicant's Signature 申請人簽署 ______________

Date 日期 ______________

6. PATIENT'S DECLARATION & SIGNATURE 病人聲明及簽署

(To be completed if the patient is a living individual and over 18 years old 只供年滿十八歲的在生人仕填寫**)**

I consent to have my medical information disclosed to the * applicant / concerned authority/ Social Welfare Department / Medical Social Services. (* Please delete as appropriate)
本人同意院方將本人之病歷資料發放給*申請人 / 有關人仕/ 社會福利署/ 醫務社會服務部。**(*** 請刪去不適用字句**)**

Patient's Signature 病人簽署 ______________

Date 日期 ______________

7. CONSENT FROM PATIENT'S PARENT OR GUARDIAN / DECEASED NEXT OF KIN

病人父母或監護人 / 死者至親同意書

(To be completed if patient is under 18 years old / patient has deceased 如病人未滿十八歲或已身故，須填寫此部份。**)**
*** Please delete as appropriate** 請刪去不適用字句

(a) **Name** 姓名**: (English** 英文**)** ______________________ **(Chinese** 中文**)** ______________

(b) **Sex** 性別**:** ☐ **Male** 男 ☐ **Female** 女 **HKID Card No.** 香港身份證號碼**:** ______________

(c) **Address** 地址**:** ____

(d) **Relationship with *patient/deceased** 與*病人/死者關係**:** ______________ **Tel. No.** 電話號碼**:** ______________

(e) **Declaration** 聲明 **(Must be Completed if patient is deceased.** 如病人已身故必須填寫。**)**

I, declare as follows: 本人聲明如下**:**

☐ **I have applied for or I have been appointed by court as the personal representative or one of the personal representatives to administer the Deceased's estate.**
本人已經向法庭申請或已經被法庭委任為死者的唯一或其中一位遺產代理人，管理死者的遺產。

☐ **I am entitled to be the personal representative of the Deceased or I can act for and on behalf of all persons who may be entitled to apply for the administration of the Deceased's estate.**
本人有權申請成為死者的遺產代理人或本人可作為及代表所有有權申請承辦死者的遺產的人士。

(f) **I consent to have the patient's / deceased's medical information disclosed to the * applicant / concerned authority / Social Welfare Department / Medical Social Services. (* Please delete as appropriate)**
本人同意院方將病人 / 死者之病歷資料發放給*申請人 / 有關人仕/ 社會福利署/ 醫務社會服務部。**(***請刪去不適用字句**)**

***Patient's Parent or Guardian / Deceased's Next of Kin's Signature**
*病人父母或監護人 / 死者至親簽署 ______________

Date 日期 ______________

For Office Use Only (只供有關部門填寫)					
Checked				**INF / PI Y / N**	**To: Finance Dept.**
INF / PI	☐	**BC / MC / DC**	☐	**Received by**	**Fr.: M(HI&R)**
Original request	☐	**Cheque / Cash**	☐	______________	**Please charge** ☐ **Medical Report at HK$895.00 x** ________
Consent	☐	**Receipt / Bill**	☐	**Remarks**	☐ **Official Signature at HK$230.00 x** ________
ID	☐	**Endorsed**	☐	______________	**Receipt no.:** ______________

(Please ✓in the appropriate box – 請在適當方格填上 ✓ 號**)**

(11.2021)