



# HOSPITAL AUTHORITY

## 醫院管理局

### Alice Ho Miu Ling Nethersole Hospital 雅麗氏何妙齡那打素醫院

For Office Use Only 只供有關部門填寫

AHN \_\_\_\_\_

Date: \_\_\_\_\_

## MEDICAL REPORT / PATIENT'S INFORMATION APPLICATION FORM

### 醫療報告及病人資料申請表格

#### 1. PARTICULARS OF PATIENT 病人個人資料

Name 姓名: (English 英文) \_\_\_\_\_ (Chinese 中文) \_\_\_\_\_

HKID Card No. 香港身份證號碼: \_\_\_\_\_ OR 或 Passport No. 護照號碼: \_\_\_\_\_

Sex 性別:  Male 男  Female 女 Age 年齡:  18 years old or above 十八歲或以上  Under 18 years old 未滿十八歲

Address 地址: \_\_\_\_\_

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
- Medical Certificate 醫生證明書 / Sick Leave Certificate 病假證明書 From 由 \_\_\_\_\_ To 至 \_\_\_\_\_
- Attendance Certificate [For Allied Health] 應診證明書 [專職醫療適用] From 由 \_\_\_\_\_ To 至 \_\_\_\_\_
- Others 其他
- Certificate of an Employee's Permanent Unfitness for a Particular Type of Work [LD424(S)]  
證明僱員永久不適合擔任某類型工作證明書 [LD424(S)]
- Application for Reimbursement/Direct Payment of Medical Expense (except drug provided by the Hospital Authority) [Form B]  
申請發還/直接支付醫療收費(由醫院管理局提供的藥物的費用除外) [表格 B]
- Please specify 請註明: \_\_\_\_\_

#### 3. HOSPITALISATION / FOLLOW-UP RECORD 急症 / 住院 / 覆診紀錄

(Note: For doctor's reference only. 請注意: 以下要求只供醫生作參考用途。)

(a) Specialty 專科部門 (Must be completed 必須填寫): \_\_\_\_\_

(b)(i) Admission Information 急症/入院資料

AE/Hospital No. 急症/住院號碼: \_\_\_\_\_ Requested Period 申請期間: From 由 \_\_\_\_\_ To 至 \_\_\_\_\_

AE/Hospital No. 急症/住院號碼: \_\_\_\_\_ Requested Period 申請期間: From 由 \_\_\_\_\_ To 至 \_\_\_\_\_

(b)(ii) Follow-up Information 覆診資料

Requested Period 申請期間: From 由 \_\_\_\_\_ To 至 \_\_\_\_\_

#### 4. REASON FOR APPLICATION 申請原因

(Note: For doctor's reference only. 請注意: 以下要求只供醫生作參考用途。)

- Insurance Claim 申請保險賠償 ( Claim Form Attached 保險表格附上)  
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, 則不會發出醫療報告。
- Employee Compensation Claims 申索工傷賠償
- Legal Proceedings 法律申訴程序
- Clinic Follow-up 醫療參考
- Immigration / Visa Application 申請移民 / 簽證
- Personal Record 個人記錄
- Others 其他 (Please specify 請註明): \_\_\_\_\_

## 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。)

Name 姓名: (English 英文) \_\_\_\_\_ (Chinese 中文) \_\_\_\_\_

HKID Card No. 香港身份證號碼: \_\_\_\_\_ OR 或 Passport No. 護照號碼: \_\_\_\_\_

Sex 性別:  Male 男  Female 女 Telephone No. 電話號碼: \_\_\_\_\_

Address 地址: \_\_\_\_\_

I agree the hospital to send the medical report / patient's information to the address above by 'Registered Mail'.

本人同意院方將醫療報告 / 病人資料以掛號形式寄往上述地址。

Signature of Applicant 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士填寫。)

I consent to have my medical information disclosed to the applicant / concerned authority.

本人同意院方將本人之病歷資料發放給申請人 / 有關人士。

Patient's Signature 病人簽署: \_\_\_\_\_ Date 日期: \_\_\_\_\_

## 7. CONSENT FROM PATIENT'S / DECEASED'S NEXT OF KIN 病人 / 死者至親同意書

(To be completed if the patient is under 18 years old / deceased. 如病人未滿十八歲或已身故，須填寫此部份。)

Name 姓名: (English 英文) \_\_\_\_\_ (Chinese 中文) \_\_\_\_\_

HKID Card No. 香港身份證號碼: \_\_\_\_\_ OR 或 Passport No. 護照號碼: \_\_\_\_\_

Sex 性別:  Male 男  Female 女 Telephone No. 電話號碼: \_\_\_\_\_

Address 地址: \_\_\_\_\_

Relationship with \*patient/deceased 與\*病人/死者關係: \_\_\_\_\_

### Declaration 聲明

(Must be completed if patient is deceased. 如病人已身故必須填寫。)

I, declare as follow:

本申請人現聲明如下:

I have applied for or I have been appointed by the Court as the personal representative or one of the personal representatives to administer the deceased's estate

本人已經向法院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遺產的人士。

I consent to have the \*patient's/deceased's medical information disclosed to the applicant/concerned authority.

本人同意院方將 \*病人/死者之病歷資料發放及申請人 / 有關人士。

Signature of Applicant 申請人簽署: \_\_\_\_\_ Date 日期: \_\_\_\_\_

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Applicant's ID checked  YES  NO

Relationship checked  YES  NO

Application fee collected  YES (Total: HK\$ \_\_\_\_\_)  NO

Legal Case?  NO  INF  PI  PL  SARS