

**For official use only**Patient ID Checked:  Original  Copy  Match with PMIAmount payable: \$ \_\_\_\_\_  cash  cheque  
 free of chargeApplicant ID:  Original  Copy  Consent signed

Receipt number: \_\_\_\_\_

 Birth certificate  Relevant person consent signed

Checked by: \_\_\_\_\_

 Certificate of marriage  Remark/Others

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

## Kwai Chung Hospital 葵涌醫院

### Medical Report Request Form 醫療報告申請表格

(  Please  where appropriate 請在適當空格上加上「」號)**1. Particulars of patient****病人資料**

- (a) Nature of identity document and number   
身份證明文件類別及號碼
- (b) Name (English)  (Chinese)   
姓名 (英文) (中文)
- (c) Date of birth (dd/mm/yyyy)  (d) Sex  Male  Female (e) Age   
出生日期 (日 / 月 / 年) 性別 男 女 年齡
- (f) Address   
地址
- (g) Daytime telephone number  (h) Other contact number(s)   
日間聯絡電話號碼 其他聯絡電話號碼

# If the HKID card number is provided, no copy or physical production of the HKID card is required in case the number provided is accurate and corresponds to the number recorded on HA's database. If not, a true copy of the HKID card will be required for verification. Alternatively, the HKID card may be physically produced for verification at our hospital.

若提交香港身份證號碼，而提交的號碼正確及與醫管局資料庫所記錄的號碼相符，無須親身出示香港身份證正本或提交真確副本。否則，須提交香港身份證的真確副本，或親身向本院出示香港身份證正本，以供查核。

# If the passport number is provided, please produce in person the original or provide a true copy of the passport of the patient when submitting this medical report request to our hospital.

若提交護照號碼，請在向本院提交本「醫療報告申請」表格時，親身出示病人的護照正本或提交真確副本。

**2. Information requested from the named hospital****向有關醫院索取的資料**

- (a) Specialty:  Psychiatric  Clinical psychology  Dietetics  Occupational therapy  Speech therapy  
所屬病科 精神科 臨床心理科 營養部 職業治療部 言語治療部  
 Physiotherapy  Others (please specify)   
物理治療部 其他 (請註明)
- (b) (1) Consultation period from  to   
求診期間 由 至
- (2) Date of admission (dd/mm/yyyy)   
入院日期 (日 / 月 / 年)
- (3) Date of discharge (dd/mm/yyyy)   
出院日期 (日 / 月 / 年)
- (4) Hospital number  (5) Inpatient ward:   
醫院登記號碼 留院期間病房
- (c) Medical report format  Completion of form (e.g. Insurance claim form)  Medical report (not completing form)  
醫療報告模式 填寫表格(如保險賠償表格) 醫療報告(不用填寫表格)
- (d) Contents of report: (This does not apply if insurance claim form attached)  
醫療報告內容包括 (如附有保險賠償表格供醫生填寫，則此欄不適用)
- Nature of sickness / disability / injury  Length of hospitalization  
疾病 / 傷殘 / 受傷性質 留院日期
- Nature of operation / treatment  Length of sick leave granted  
手術 / 治療的性質 病假日期
- An assessment of the degree of permanent disability following sickness / injury  
疾病 / 受傷而引致的永久傷殘程度評估
- An assessment of whether the patient will be fit to work in the job at the time of sickness / injury  
評估病人將來是否適宜恢復其在患病 / 受傷前負責的工作
- Others (please specify)   
其他 (請註明)

- (e) Purpose of medical report:  
醫療報告用途

<p><b>For general purpose(s)</b> 作為一般目的用途</p> <p>(1) <input type="checkbox"/> A general medical report for: <input type="checkbox"/> Future medical purposes 一般性質的醫療報告以供 日後醫療用途</p> <p style="margin-left: 200px;"><input type="checkbox"/> Others (please specify) 其他 (請註明) _____</p> <p>(2) <input type="checkbox"/> A supplementary medical report <i>(Please attach a copy of the previous medical report, if available, for ease of reference)</i> 解釋或跟進一個已發出的醫療報告 (如有以前的醫療報告, 請附上副本以作參考)</p> <p><i>Please specify items to be included in this supplementary medical report:</i> 請註明此跟進醫療報告所應包括之事項</p> <p>_____</p> <p>_____</p>
<p><b>For specific purpose(s)</b> 作為指定用途</p> <p>(1) <input type="checkbox"/> Insurance claim 申索保險賠償</p> <p style="margin-left: 20px;"><input type="checkbox"/> Attached insurance claim form to be completed by doctor 附上保險賠償表格供醫生填寫</p> <p style="margin-left: 20px;"><input type="checkbox"/> No insurance claim form 沒有保險賠償表格</p> <p>(2) <input type="checkbox"/> Employee compensation claims 申索工傷賠償</p> <p>(3) <input type="checkbox"/> Legal proceedings 法律申訴程序</p> <p>(4) <input type="checkbox"/> Certification of sickness / injury for _____ 證明疾病 / 受傷以用作 _____</p> <p>(5) <input type="checkbox"/> Certification of sickness / disability in support of rehousing application 證明疾病 / 傷殘用以支持申請公屋徙置</p> <p>(6) <input type="checkbox"/> Others (please state reason) _____ 其他 (請列明理由) _____</p> <p>_____</p>

**3. Person to whom the medical report is to be sent**  
醫療報告接收人

The patient and/or the patient's parent/guardian by signing this form consents to the relevant HA hospital disclosing and sending the medical report to the following person:

病人及/或其父/母/監護人簽署此表格代表病人及/或其父/母/監護人同意有關之醫院管理局醫院向下述人士透露及發出其醫療報告

(a)	Name (English) 姓名 (英文)	(Chinese) (中文)
(b)	Nature of identity document and number 身份證明文件類別及號碼	
(c)	Address 地址	
(d)	Daytime telephone number 日間聯絡電話號碼	(e) Other contact number 其他聯絡電話號碼

# Please produce in person the original or provide a true copy of the identity document of the individual to whom this medical report is to be sent (if not the patient). This does not apply if the recipient is a limited company such as an insurance company.  
如果此醫療報告非由病人本人接收, 請親身出示接收人的身份證明文件或提交真確副本。  
如若接收人為一有限公司(如保險公司), 則此欄不適用。

#### 4. Declaration and Signatures

##### 聲明及簽署

The patient and (where applicable) patient's parent / guardian declare that the information given in this medical report request form is accurate.

病人及病人父 / 母 / 監護人 (如適用者) 謹此聲明在本「醫療報告申請表格」內提供的資料準確無訛。

Signature of the patient

Date (dd/mm/yyyy)

病人簽署

日期 (日/月/年)

**If application by patient's parent / guardian:** (for patient under 18 years old or legal guardian)

**若由病人父 / 母 / 監護人提交申請** (此欄適用於未滿十八歲 或 因精神狀況而不能處理本身事務之病人)

Name of the patient's parent / guardian (in block letters)

病人父 / 母 / 監護人姓名 (請用正楷填寫)

Nature of identity document and number

身份證明文件類別及號碼

Relationship with the patient

與病人關係

Signature

簽署

Date (dd/mm/yyyy)

日期 (日/月/年)

#### 5. Mode of Collection

##### 領取方式

Please select collection method

請選擇領取方法:

In person  
親自領取

By registered mail  
掛號郵件

## Notes for application for medical report

### 申請醫療報告須知

1. According to the Hospital Authority's policy, a minimum of HK\$1,100 per medical report per specialty and subject to a maximum of HK\$4,400 will be charged.  
根據醫院管理局政策，每份醫療報告 / 每個專科最低收費為港幣\$1,100，最高收費為港幣\$4,400。
2. The hospital will generally keep in-patient and specialist out-patient psychiatric records for 10 years.  
本院一般只保留病人十年的住院及專科門診精神科紀錄。
3. Application made by relevant person should obtain patient's written consent.  
有關人士須取得病人的書面同意，方可申請。
4. Applicant and concerned parties should present all relevant documents for record and verification of identity. The documents include:  
申請人及有關人士必須出示下列有關證明文件，以資紀錄及核實身份，文件包括：
  - 4.1 If the HKID card number is provided, no copy or physical production of the HKID card is required in case the number provided is accurate and corresponds to the number recorded on HA's database. If not, a true copy of the HKID card will be required for verification. Alternatively, the HKID card may be physically produced for verification at our hospital.  
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  - 4.2 **If the patient is under 18:** Birth certificate **or** legal custody paper **AND** parent / guardian's written consent (if application made by relevant person) and attach a copy of documentary evidence to support the relationship with the data subject.  
若病人在十八歲以下：出生證明書 **或** 法定管養權證明書 **及** 父 / 母 / 監護人之書面同意(適用於由有關人士提出申請)，並附上與資料當事人關係的證明文件副本。
  - 4.3 A court document issued by courts in Hong Kong appointing the relevant person to manage the affairs of the patient (if applicable)  
香港法院簽發任命有關人士管理病人事務的法院文件 (如適用)
5. Please provide as far as possible all relevant patient's information, such as dates, receipts and specialist outpatient clinic case number, etc.  
請儘量提供所有有關病人接受本院治療的資料，如日期、住院收據、專科門診號碼等。
6. For completing the medical insurance form issued by insurance company, the insurance form has to be submitted together with the application form. Please complete the part I of the insurance form with patient's signature. Such request should be made only after the patient is discharged.  
有關申請填寫保險公司發出的醫療保險表格，請將該表格連同申請表一併交回。申請人並須填妥表格上的第一部份，此部份必須有病人簽署。此項申請，需待病人出院後才可辦理。
7. Please fill in the application form carefully. Insufficient or inaccurate information will lead to delay or rejection.  
請清楚填妥申請表內每一項資料，若所填資料有不足或錯誤，此項申請將受到延誤或拒絕。
8. The applicant should settle the fee at the **Shroff Office** upon submission of the application form. Payment by cheque should be crossed and made payable to the "**Hospital Authority**".  
遞交醫療報告申請表時，申請人須到繳費處繳交費用。如以支票付款，抬頭請寫「醫院管理局」，並加劃線。
9. For application by post, send the duly completed application form together with a crossed cheque made payable to "**Hospital Authority**" to:  
如以郵遞方式申請，請將填妥表格連同劃線支票，抬頭請寫「醫院管理局」，並寄回：

Health Information and Records Department at 1/F, Kwai Chung Hospital  
Day Recovery Centre, 3-15 Kwai Chung Hospital Road, New Territories  
新界葵涌醫院路 3-15 號 葵涌醫院日間復元中心 1 樓 醫療資訊及紀錄部
10. Please do not send cash by post.  
切勿郵寄現金。
11. No refund will be made even the application is withdrawn before the report is issued.  
申請人即使在醫療報告發出前撤銷申請，已繳費用，概不發還。
12. In general, each medical report application will be completed in around 8 weeks. Longer processing time is required depending on individual specialty, or if multi-specialties or several claim forms are involved.  
一般情況下，每份醫療報告申請需時約 8 星期才能完成。因應個別專科，或申請涉及跨專科多份醫療報告或表格，處理時間會較長。
12. Each medical report is written in English only.  
每份醫療報告均只用英文書寫。
13. Should you have any queries, please feel free to contact our Health Information and Records Department.  
如有任何查詢，請聯絡本院醫療資訊及紀錄部。

Tel 電話: 2959 8028

Fax 傳真: 2307 6521

Email 電郵: kch.enquiry@ha.org.hk