



Cheshire Home, Shatin
沙田慈氏護養院

(For Office Use Only 只供有關部門填寫)

MRO/MR _____

Date: _____

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"醫療報告及病人資料申請須知")

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: (The hospital will send the medical report/patient's information to the following address by "Registered Post" if the patient is the applicant 如病人為申請人，醫療報告/病人資料將以掛號形式寄往下述地址)

(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 Medical Certificate 醫生證明書 From 由 _____ To 至 _____

Birth Date & Time 出生日期及時間 Sick Leave Certificate 病假證明書 From 由 _____ To 至 _____

Proof of Date of Death 死亡日期證明 Date of Admission & Discharge 出入院日期

Discharge Slip 出院紙 Attendance Record 到診紀錄 Medical Expenses Record 醫療費用紀錄

Certificate of an Employee's Permanent Unfitness for a Particular Type of Work 證明僱員永久不適合擔任某類工作證明書

<Please read the Notes of Application for (Form 1) 請先參閱(表格一)的申請須知>

Others 其他: _____

3. **HOSPITALIZATION RECORD 住院紀錄**

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

(a) **Must be Completed 必須填寫** Specialty 專科部門: _____

(b) Admission Information 入院資料

Hospital Number 住院號碼: _____ Request Period 申請期間 From 由 _____ To 至 _____

Hospital Number 住院號碼: _____ 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 保險表格附上)

If the claim form is being completed, no additional medical summary will be given. 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。

Employee compensation claims 申索工傷賠償

Legal proceeding 法律申訴程序用途

Support of application for family reunion 協助申請家人團聚

Clinical Follow-up 醫療參考

Immigration / Visa Application 申請移民 / 簽證

Personal Record 個人紀錄

Others-Please Specify 其他-請註明 _____

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

Last updated on Jan 2022

5. PARTICULARS OF APPLICANT 申請人資料

(To be completed if the applicant is a person other than the patient 如病人為申請人則此項不須填寫)

- (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: _____ Tel. No.電話號碼: _____
- (c) Address 地址: (The hospital will send the medical report / patient's information to the following address by "Registered Post" 醫療報告 / 病人資料將以掛號形式寄往下述地址予申請人)

- (d) Relationship with patient 與病人關係: _____

Applicant's Signature 申請人簽署 _____
Date 日期 _____

6. PATIENT'S CONSENT 病人同意

(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.
本人同意醫院管理局將本人之病歷資料發放給申請人/有關人仕。

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 patient is under 18 years old / patient has deceased 如病人未滿十八歲或已故，請填寫以下資料)

* Please delete the appropriate item 請刪去不適用的項目

- (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: _____ Tel. No.電話號碼: _____
- (c) Address 地址: _____
- (d) Relationship with *patient/deceased 與*病人/死者關係: _____

(e) To be completed if apply for **deceased's** medical report/information 只供申請**已故病人**的醫療報告/資料填寫
Declaration 聲明

I, declare as follows: 本人聲明如下:

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.
本人同意醫院管理局將病人/死者之病歷資料發放給申請人/有關人仕。

Patient's / Deceased's Next of Kin's Signature 病人/死者近親簽署 _____
Date 日期 _____

FOR OFFICE USE ONLY 只供有關部門填寫

Applicant's ID checked Y / N

To: Shroff Office

Relationship checked Y / N

Please charge at \$ _____

INF Y / N

PL Y / N

PI Y / N

MRO, SCH



Cheshire Home, Shatin
Hospital Authority

Notes of Application for Medical Report / Patient's Information

1. Consent of patient / patient's legal guardian should be obtained for an applicant to apply for the patient's medical report / patient's information.
2. Consent of patient's parent / guardian should be obtained for an applicant to apply for the medical report / patient's information if the patient is under 18 years of age.
3. Consent of patient's personal representative should be obtained for an applicant to apply for the medical report / patient's information if the patient is a deceased.
4. All relevant supporting documents of the applicant, patient, and concerned parties should be presented for verification of identity upon request. Copy of the documents may be required if necessary. Examples of the supporting documents are:
 - Hong Kong Identity Card
 - Marriage Certificate
 - Probate or Letter of Administration (if the patient is deceased)
5. The specialty responsible for completion of medical report / patient's information and all relevant information about the attendance of the patient, including dates, receipts and follow-up card must be specified upon submission of request.
6. If the reason for request is "Claim for Compensation / Insurance", please attach the relevant insurance form. Doctor will complete the medical report either in essay form or in the provided form.
7. An authorized signature of the patient is required if there is any amendment made on the documents / application form.
8. According to the policy of Hospital Authority, \$895 should be levied for each specialty of medical report. A maximum of \$3,580 will be charged per hospitalization. \$230 will be charged for general requests (Proof of Date of Death, Date of Admission & Discharge, Birth Date & Time, Attendance Record, copy of Medical Certificate). Regarding the charges for other special requests, please contact our staff.
9. Charges for all requests should be paid during submission. The minimum charge of HK\$895 should be paid when submitting an application for medical report. Payment by cheque should be crossed and made payable to the 'Hospital Authority'.
10. Under no circumstances will the application for medical report / patient's information be processed without receiving consent from patient or patient's authorized person, checking original and copy of relevant documents and paying the charges.
11. *No refund* of the charge for medical report / patient's information will be made once an application is made.
12. All medical reports / patient's information are written in English. The information provided will be until the date of application or subject to the doctor's decision on the relevancy of the case.
13. Each medical report / patient's information will be completed in around eight weeks. For any amendment request, please submit the original copy of medical report / patient's information. Please note that such amendment is subject to our doctors / hospital management's final decision.
14. All medical report / patient's information will be sent to the applicant by "Registered Post" unless specified upon application.
15. If you have any queries, please contact us at

Enquiry Number : (852) 2636 7288 / 2636 7208
Facsimile Number : (852) 2635 1492
Address : General Office, G/F, Cheshire Home, Shatin
30 A Kung Kok Shan Road, Shatin, N. T.
Office Hour : Monday to Friday: 8:45am - 5:30pm
Saturday, Sunday and Public Holiday: Closed

Remark: "Original consent" or "certified true copy" of the consent is required for application of medical report / patient's information.