The Hong Kong Anti – Cancer Society
Jockey Club Cancer Rehabilitation Centre
Referral Form

Telephone : 3921 3721 (R2) Fax : 3921 3722 (R2)

***Admission time : 09:00 to 18:00)(Sat 09:00 – 11:00)**
(Special arrangement on Public Holiday)*

Patient's particulars

Name: _____(Chinese)
Name: _____(English)
HKID / Passport no.: _____
Sex /Age: _____
Telephone no. :_____(Home)
_____(Mobile)

Booking Date : _____
Address : _____
_____
_____
_____

Contact person

Name: _____ Relationship: _____ Contact no. : _____

Reasons for Referral

☐ In-patient rehabilitation care ☐ Day care service ☐ Others _____

Diagnosis **Allergy History :** _____

Any infectious disease : ☐ No ☐ Yes , please specify: _____
Require frequent transfusions : ☐ No ☐Yes , please specify: _____

Present Condition and symptoms

Present medication (+ Dosage)

Please enclose pathology report/medical report/discharge summary/other confirming evidence.
Remarks : _____
Will the referring unit continue to follow up the case ☐ Yes ☐ No
Please provide the date of next follow up _____(Date / Month / Year)
Remarks : _____

Referred by (BLOCK letters)

Referring Doctor : _____ (Block Letter) _____ (Signature)
Hospital (Unit / Clinic) _____
Tel & Fax No. of Referring Doctor: _____ (Tel) _____ (Fax)

Date of referral received : _____ Date of assessment: _____
Remarks : _____ Sign : _____