香港防癌會賽馬會癌症康復中心

The Hong Kong Anti-Cancer Society
Jockey Club Cancer Rehabilitation Centre

Doctor's Referral Form

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

*Admission Time: 09:00 – 17:00 (Monday – Friday)

Patient's particulars

Name: _____ (Chinese) Booking Date: _____

Name: _____ (English) Address: _____

HKID / Passport No.: _____ _____

Sex: _____ Age: _____ _____

Tel No.: _____(Home) _____(Mobile) _____

Contact Person

Name: _____ (Chinese) Relationship with patient: _____

Name: _____ (English) Tel No.: _____(Home) _____(Mobile)

Reasons for Referral

☐ Rehabilitation care ☐ Respite care ☐ Palliative / End of life care ☐ Others: _____

Diagnosis **Allergy History:** _____

_____

_____

_____

Any infectious disease: ☐ No ☐ Yes, please specify: _____

Require frequent transfusions: ☐ No ☐ Yes, please specify: _____

Present condition and symptoms, current treatment and care:

_____

_____

_____

_____

_____

_____

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 letters) Signature: _____

Hospital (Unit / Clinic): _____

Tel & Fax No. of Referring Doctor/Unit : _____ (Tel) _____ (Fax)