



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 3863 / 3921 3835 Fax: 3921 3722

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 : _____ (Tel) _____ (Fax)