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

Telephone : 3921 3720 (R2) Fax : 3921 3722 (R2)

Admission time : 09:00 to 16:00 Mon-Fri (except 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 / Mouth / 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 : _____