Patient Label	**MEDICAL ALERT/ALLERGY**

*****PLEASE USE BLOCK LETTERS & WRITE CLEARLY*****

Surname:		First Name:	
Date of Birth:		Previous Name: (if applicable)	
Document Type ☐ Hong Kong Identity Card ☐ Passport ☐ Others:_____	Document No.:	Country of Issue:	Ethnicity:
Mobile:		Room Request (Subject to availability on admission) ☐ VIP ☐ Private ☐ Twin ☐ Standard	
Email:			

Are you Hong Kong Resident? ☐Yes ☐No

Spouse Hong Kong Resident? ☐Yes ☐No

Previous MIH Admission? ☐Yes ☐No

Name of Doctor & Clinic Tel:

Client Signature:

LMP: **E**xpected **D**ate of **D**elivery: **G** **P**

Previous Pregnancies

Date of Birth	Gestation	Complications	Type of Delivery	Sex, Weight

GBS STATUS : ☐ **Negative** ☐ **Positive**

Family History/other:

VTE Risk Assessment

BMI : <30 ☐ or ≥ 30 ☐

	Yes	No
Smoker:	☐	☐
Multiple pregnancy:	☐	☐
History of VTE:	☐	☐
Family History of VTE:	☐	☐
History of Thrombocytopenia:	☐	☐

Blood Results Please attach Laboratory Copy of Blood Results

Please Complete & Fax to Maternity 2849 6246 at booking *& update at 36 weeks*