



# Obstetrical Pre-Admission Form

NEWBORN INFORMATION

Expected Date of Birth \_\_\_\_\_  
Day / Month / Year

**PATIENT'S PERSONAL INFORMATION (Please see page 2 for Insurance Information)**

Family Name		First Name Used	Surname at Birth/Alternate Names		Date of Birth <small>Day / Month / Year</small>
Mailing Address			City/Town/Village	Province	Postal Code Country
Phone Number			Have you been a patient in this hospital before? <input type="checkbox"/> No <input type="checkbox"/> Yes Date: _____		
Family Physician	Referring Obstetrician/Midwife	Would you like to have your place of worship listed in case your clergy or designate are visiting in the hospital? <input type="checkbox"/> Declined <input type="checkbox"/> Yes			
Do you have any Allergies or Medical Alerts? <input type="checkbox"/> No <input type="checkbox"/> Yes					

**Contact Information:** (name of contact in case of emergency. (Spouse, parent, guarantor, etc.)

Full Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Full Address: \_\_\_\_\_ Alternative Number: \_\_\_\_\_  
 Next of Kin: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Full Address: \_\_\_\_\_ Alternative Number: \_\_\_\_\_

**HEALTH CARE COVERAGE**

Is the patient covered under Ontario Health Insurance Plan <input type="checkbox"/> No <input type="checkbox"/> Yes Full Name on Health Card: _____	Health Insurance Number
--	-------------------------

**OUT OF PROVINCE INFORMATION**

Address of Province of origin _____ _____ Home Phone Number : _____ Business Phone Number: _____	Is this: <input type="checkbox"/> Temporary move? <input type="checkbox"/> Permanent move? <hr/> Provincial Health Care Number _____ Expiry Date: _____
--	--

**OUT OF COUNTRY INFORMATION (Please see page 3 to fill out Insurance Information.)**

Address of Country of origin _____ _____ Home Phone Number: _____ Business Phone Number: _____	Is this: <input type="checkbox"/> Temporary Move? <input type="checkbox"/> Permanent Move? <hr/> If Temporary: (reason) <input type="checkbox"/> Visiting <input type="checkbox"/> Other: _____ <input type="checkbox"/> Temporary Employment Employer : _____ Address and Phone: _____
--	--



**What to bring when having your baby  
at Guelph General Hospital**

Checklist for Mom to bring:

Ontario Health Card and other Insurance information	
Medications you take regularly in labeled pharmacy containers	
Large sanitary pads; enough for three days and nights	
Clothing for yourself (i.e. slippers, socks, nightgowns, pyjamas, underwear and bra) – no underwire	
Nursing pads for breastfeeding mom (optional)	
Personal care items (i.e. toothbrush, toothpaste, deodorant, soap, shampoo, conditioner, lip balm, etc)	
Pens to fill out forms and for keeping track of when baby feeds	

- If you bring food to place in the pantry located across the nursing station, please label with your name
- **Please note the hospital DOES NOT supply the following items: DIAPERS, PADS, AND MESH UNDERWEAR**

Checklist for Baby:

Newborn size diapers (approx. 25 diapers), Wipes, Vaseline	
Receiving blankets	
Several pairs of sleepers and clothes for hospital and for going home	
hats, mittens, and socks	
Safety approved infant car seat <a href="https://www.tc.gc.ca/eng/motorvehiclesafety/safedrivers-childsafety-car-time-stage1-1084.htm">https://www.tc.gc.ca/eng/motorvehiclesafety/safedrivers-childsafety-car-time-stage1-1084.htm</a>	

- Please familiarize yourself with the car seat prior to discharge; your nurse is unable to help because every car seat is so different.

Checklist for Other:

Extra pillows (there is never enough)	
Pyjamas, extra blanket and /or sleeping bag for partner	
Breastfeeding pillow (optional)	
Kleenex	
Camera, personal mp3/iPod	
Snacks for partner	
Phone charger	

- **Please DO NOT bring perfumes, latex, and lilies as some people have severe sensitivities or allergies**



## REQUEST FOR SEMI-PRIVATE OR PRIVATE ROOM

The Family Birthing Unit has three types of patient rooms available.

- Ward Rooms (covered by OHIP)
- Semi-Private Rooms (\$215 per day)
- Private Rooms (\$250 per day)

Provincial Health Insurance provide basic Ward Coverage (4 beds per room) to their insured at no cost.

Many patients have coverage for semi-private and private rooms through their extended health benefits. Please check your insurance policy coverage carefully before requesting preferred accommodation.

When choosing a preferred room please find out your available coverage from your insurance carrier. The benefit booklet supplied by your employer (or your partners employer) may provide this information

Check  ward coverage if you are unsure or can't confirm your insurance coverage to make sure you're not unexpectedly billed.

If you have no insurance coverage but choose a private or semi room the hospital will send you a bill for the room charges by mail after you are discharged. You may also receive a bill for any amount outstanding on your account that your insurance won't pay for such as a deductible.

Do you have supplementary insurance for semi or private coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes	
<b>Please COMPLETE if you have supplementary insurance</b>	
Name of insurance company	Policy/Group #
Name	Certificate or I.D.#
Subscriber's Name	Employer's Name

**Please check your insurance policy coverage before requesting preferred accommodation. Payment will be expected after discharge from the hospital of any additional cost over and above you insurance coverage.**

Requests	Room	CDN Residents	Non-Residents of Canada
	Ward (4 beds per room)	\$0.00/day	\$0.00/day
	Semi-Private (2 beds per room)	\$215.00/day	\$430/day
	Private (1 bed per room)	\$250.00/day	\$500/day

If you request and receive a semi-private or private room, we will bill your insurance company on your behalf. If your insurance company **does not** cover the full amount of your hospital bill, the **responsibility for full payment remains with you.**

### Authorization

- I certify the information given on this form is true, correct and complete to the best of my knowledge.
- I hereby authorize Guelph General Hospital to release medical information required for this claim to the insurance companies involved if required and/or requested by your insurance carrier.
- I hereby assign to Guelph General Hospital all of the hospitalization benefits provided by my hospital insurance to satisfy my indebtedness or that of my dependent.

### Payment of account

- I agree to make full and immediate payment for charges not covered by any other agency.

\_\_\_\_\_  
Signature of Patient/Signing Authority

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient (for signing authorities only)



**INPATIENT FINANCIAL RESPONSIBILITY FORM  
(Patient's with no valid OHIP coverage)**

This form is intended for patients without valid OHIP coverage. This form provides you with information regarding our Inpatient Financial Responsibility policy and rates. We ask that you read and sign this form to acknowledge your understanding of our rates and policies which are as follows:

<b>Ward Coverage Daily Rates</b>	
Ontario Resident WITHOUT valid Ontario Health Insurance (OHIP)	\$1294.00/day
Landed Immigrant Status	\$1294.00/day
Canadian Resident of another Province WITHOUT a valid provincial health card	\$1294.00/day
Non-Resident of Canada	\$2588.00/day
Refugee status – if not covered by F.A.S.	\$1294.00/day

**Financial Policies:**

- If I am uninsured, I agree to pay for the medical services rendered to me.
- If I am the guardian of a minor patient. I agree to pay for medical services rendered to the minor patient under my care.
- If I am insured, Guelph General Hospital will bill my insurance for me. I agree to provide the most correct and updated insurance information.
- I am responsible for coinsurance, deductibles, and all other procedures and treatments not covered by my insurance plan.
- I understand that failure to pay for treatment or care may result in my account being sent to a collection agency.

<b>Current Insurance</b>	
Name of Insurance:	
Policy/Group #:	
Subscribers Name:	
Coverage:	
Employer:	

**Authorization**

- I certify the information given on this form is true, correct and complete to the best of my knowledge.
- I hereby authorize Guelph General Hospital to release medical information required for this claim to the insurance companies involved if required and/or requested by your insurance carrier.
- I hereby assign to Guelph General Hospital all of the hospitalization benefits provided by my hospital insurance to satisfy my indebtedness or that of my dependent.

**Payment of account**

- I agree to make full and immediate payment for charges not covered by any other agency.

\_\_\_\_\_  
Signature of Patient/Signing Authority

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient (for signing authorities only)