Place Patient Form Label Here

PHC PRE-ADMISSION INFORMATION

* 3 9 1 9 *

Booking Form
Non-Surgical

Please complete and return promptly

Date of form completion: _____

ADMISSION INFORMATION

SITE:

☐ **Holy Family Hospital**
Admitting Department
7801 Argyle Street, Vancouver, BC V5P 3L6

☐ **Mount Saint Joseph Hospital**
Admitting Department
3080 Prince Edward Street, Vancouver, BC V5T 3N4

☐ **St. Paul's Hospital**
Pre-Admission Clinic
1081 Burrard Street, Vancouver, BC V6Z 1Y6

Type of Admission:

☐ Inpatient
☐ Surgical Day Care
☐ Maternity
Expected date of delivery: _____

Expected date of admission / visit: _____

Have you ever been a patient at Providence Health Care? ☐ Yes ☐ No

PERSONAL INFORMATION

Patient's Legal Name: _____
Last Name | First Name | Middle Name | Other names used

Sex: ☐ Male ☐ Female **Date of Birth:** dd/mmm/yyyy _____

Marital Status: ☐ Single ☐ Separated ☐ Widow ☐ Married ☐ Common-law ☐ Companion live-in

If you would like your faith or denomination noted on your record, please indicate it here: _____

If you prefer communication in a language other than English, please indicate it here: _____

Personal Health Number: (CareCard number) _____

Family Physician or clinic you attend: _____

Admitting Physician / Surgeon / Obstetrician / Midwife: _____

ACCIDENT

Is this visit due to an accident? ☐ No ☐ Yes If yes, date of accident: _____

Time of accident: _____ Place of accident: _____

Details of accident: _____

ADDRESS

Patient's Permanent Address: _____
Street

City | Province | Postal Code | Country

How long have you lived at the above address? _____

Phone: Cellular: _____ Home: _____

Email address: _____
(Email and cellular phone texting may be used for follow-up by PHC)

Previous Address: _____
(If less than six months at current address) Street

City | Province | Postal Code | Country

PLEASE COMPLETE THE BACK OF THIS FORM

Place Patient Form Label Here

PHC PRE-ADMISSION INFORMATION

3919

Booking Form
Non-Surgical

PERSONS TO CONTACT

Legal Next-of-Kin: _____ **Relationship:** _____
Name (spouse if married)

Address of Next-of-Kin: _____
(If different than patient) Street

_____
City Province Postal Code Country

Telephone number of Next-of-Kin: (if different from patient) **Cellular:** _____

Home: _____

Emergency Contact: (if different from Next-of-Kin) _____

Relationship: _____ Phone: _____

Address of Emergency contact: _____
(if different than patient) Street

_____
City Province Postal Code Country

RESIDENT / CITIZEN / IMMIGRANT / VISA / REFUGEE

- ☐ BC Resident
- ☐ Canadian Citizen
- ☐ Landed Immigrant
- ☐ Visa
- ☐ Refugee

If less than 3 months, date arrived in BC: _____

If landed immigrant or refugee, without a BC CareCard, **OR** on a visa, please provide a photocopy of your immigration or visa paper.

If refugee, please provide copies of both refugee documents.

INSURANCE INFORMATION

If **WorkSafeBC** (WSBC), please provide WSBC Claim Number: _____

If **ICBC** please provide ICBC Claim Number: _____

ICBC Adjuster's name: _____

Office: _____

EXTENDED HEALTH COVERAGE / ACCOMMODATION PREFERENCE

Accommodation Preference:

☐ Standard ward - _____ No charge.

☐ Private room / Private bath $195.00 ☐ Semi-private room $165.00

Private and semi-private rooms are subject to availability.
A deposit may be required for private and semi-private room requests. Prices are subject to change.

Signature: _____

Place Patient Form Label Here

DELIA TETRAULT (DT) PROCEDURE ROOM PRE-OP HISTORY PATIENT QUESTIONNAIRE (MSJ)

* 3 0 0 7 *

Medical Questionnaire

Dear Patient: Please complete this health history questionnaire to the best of your ability. Check all answers that apply. You can write additional detail in the "specify" or "comments" section. Give the completed form to the team at your surgeon's office.

Patient name: _____

Date of birth (dd/mmm/yyyy) _____ **Gender:** ☐ Male ☐ Female ☐ Other: _____

Address: _____

Preferred phone number: _____ **Email:** _____

Height: _____ feet _____ inches ***or*** _____ cm **Weight:** _____ lb ***or*** _____ kg

Preferred language: _____ ☐ Interpreter required

Family Doctor: _____

Do you have any allergies:

☐ Medication *(specify)*: _____
☐ Food *(specify)*: _____
☐ Latex ☐ Tape/bandages ☐ Iodine ☐ IV contrast
☐ Other allergies *(specify)*: _____

Do you:

☐ Smoke tabacco of any kind? (e.g. cigarettes, cigars, pipes, vapes) *(specify)*: _____
How many per day: _____ *For how many years:* _____
☐ Drink alcohol *How many drinks per week:* _____
☐ Use non-prescribed substances? *(specify)*: _____ *How often:* _____

Do you have any heart problems? *Specify below*

☐ High blood pressure ☐ Chest pain/angina → *Last episode:* _____
☐ Irregular heart beat ☐ Heart surgery ☐ Pacemaker or implantable defibrillator
☐ An artificial heart valve ☐ Bleeding/clotting disorder ☐ Hemophilia
☐ Other heart conditions: *(specify)*: _____

Do you take blood thinners such as:

☐ warfarin (Coumadin) ☐ clopidogrel (PLAVIX)
☐ Other blood thinners *(specify)*: _____
☐ Do you take Aspirin (ASA) regularly, why? _____

Do you have any breathing problems? *Specify below*

☐ Asthma ☐ Chronic Obstructive Pulmonary Disease (emphysema or chronic bronchitis)
☐ Home oxygen ☐ Inhalers (puffers), how often? _____
☐ Sleep apnea ☐ Use a CPAP/ BIPAP machine
☐ Active tuberculosis ☐ A problem lying down for 30 minutes or more because of difficulty breathing?
☐ Other breathing problems *(specify)*: _____

DELIA TETRAULT (DT) PROCEDURE ROOM PRE-OP HISTORY PATIENT QUESTIONNAIRE (MSJ)

* 3 0 0 7 *

Medical Questionnaire

Place Patient Form Label Here

Do you have:

- ☐ Diabetes → ☐ on insulin ☐ on diabetic pills ☐ diet controlled
- ☐ Kidney disease → ☐ on dialysis
- ☐ Thyroid disease
- ☐ Epilepsy/seizures/convulsions - *Last episodes:* _____
- ☐ Dizziness
- ☐ Fainting spells
- ☐ Memory problems or confusion
- ☐ History of stroke or stroke like symptoms
- ☐ A disease that affects your muscles and nerves
- ☐ History of extreme confusion after an operation

OTHER IMPORTANT MEDICAL INFORMATION	Yes	No	Comments
Have you had pervious surgery? *Last surgery date:* _____			
Have you had serious problems following on anesthetic (e.g. malignant hyperthermia?)			
Do you have family (blood relatives) who have had serious problems following an anesthetic?			
Have you had problems or reaction to local freezing (anesthetic)?			
Have you have had an infection requiring isolation in the hospital?			
Are you prone to having anxiety attacks? Do you take medication for it?			
Do you have a chronic pain disorder?			
Do you have problems with your balance?			
Have you had a fall in the past 3 months?			
Do you use a wheelchair, cane, scooter or other walking aid?			
Do you wear a hearing aid(s)?			

Do you have any other illness, limitations or concerns we should know about?

List all of the medications that you take: (including herbal, vitamins, and non-prescription drugs)

Who is the person responsible for picking you up and driving you home after your surgery?

Name: _____ Phone number: _____

Patient Questionnaire completed by:

☐ Patient ☐ Other, specify relationship to the patient: _____

Print name	Signature	Date (dd/mmm/yyyy)