



PRE-ADMISSION INFORMATION



* 3 9 1 9 *

Patient/Family
Created Documents

Place Patient Label Here

Please Complete and return promptly

Date: (dd/mmm/yyyy) _____

<input type="checkbox"/> St. Paul's Hospital 1081 Burrard Street, Vancouver, BC V6Z 1Y6	<input type="checkbox"/> Mount Saint Joseph Hospital 3080 Prince Edward Street, Vancouver, BC V5T 3N4	Type of Admission: <input type="checkbox"/> Inpatient <input type="checkbox"/> Surgical Day Care <input type="checkbox"/> Maternity: Expected date of delivery:(dd/mmm/yyyy) _____
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Expected date of admission / visit: _____

Have you ever been a patient at Providence Health Care in the past? Yes No

PERSONAL INFORMATION

Patient's Legal Name: _____

_____	_____	_____	_____	_____
	Last Name	First Name	Middle Name	Other names used

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

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: _____

Do you wish to self-identify as an Indigenous person (answering this question is voluntary) Yes No Prefer not to Answer

If yes, do you identify as First Nations Métis Inuit Other: _____

Would you like to be connected to cultural support services? Yes No

Personal Health Number: (CareCard number) _____

Primary Care Provider or clinic you attend: _____

Admitting Physician / Surgeon / Obstetrician / Midwife: _____

ACCIDENT

Is this visit due to an accident? No Yes If yes, date of accident: (dd/mmm/yyyy) _____

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: Home: _____ Alternate phone: _____

Email address: _____

I consent to receiving follow up information via text or email message

Previous Address: _____

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

City _____ Province _____ Postal Code _____ Country _____

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PERSONS TO CONTACT

Legal Next-of-Kin: _____ Relationship: _____
Name

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

City Province Postal Code Country

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

Home: _____ Alternate phone: _____

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

Relationship: _____ Phone: _____

Address of emergency contact: _____ Street
(If different than patient)

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.

Patient Signature: _____ Date :(dd/mmm/yyyy) _____

If you are not the patient, what is your relationship to the patient? _____