Place Patient Label Here



Please Complete and return promptly

Date: (dd/mmm/yyyy)				
St. Paul's Hospital 1081 Burrard Street, Vancouver, BC V6Z 1Y6	☐ Mount Saint Joseph Hospital 3080 Prince Edward Street, Vancouver, BC V5T 3N4	Type of Admissio ☐ Inpatient ☐ S ☐ Maternity:	on: Surgical Day Care	
•	/ visit:t at Providence Health Care in the	· 		
PERSONAL INFORM	ATION			
Patient's Legal Name:	Last Name	First Name	Middle Name	Other names used
Gandar: Mala Fama	lle Other:		dd/mmm/yyyy)	
Marital Status: Sin	gle Separated Common-law	Widow	nion live-in	
If you would like your faith or oplease indicate it here:	denomination noted on your record	f, If you prefer c indicate it here	ommunication in a language e:	e other than English, please
Primary Care Provider or cli	nic you attend: // Obstetrician / Midwife:			
Is this visit due to an accide	ent? No Yes If yes, date	of accident: (dd/mmm	/yyyy)	
Time of accident:		Place of accide	nt:	
Details of accident:				
ADDRESS				
Patient's permanent addres	s:Street			
City	Province	Posta	ıl Code	Country
How long have you lived at the	above address?			
Phone: Home:		Alternate ph	one:	
	w up information via text or email r	message		
Previous Address: (If less th	an six months at current address)		Street	
City	Province	Posta	ıl Code	Country

PRE-ADMISSION INFORMATION

Place Patient Label Here



PERSONS TO CONTACT						
Legal Next-of-Kin:	Relationship:					
Name						
Address of Next-of-Kin:(If different than patient)		Street				
		2.101				
City Telephone number of Next-of-Kin:	Province (if different from patient)	Postal Code	Country			
·		Allerente				
Home:		Alternate pnone:				
Emergency Contact: (if different from	om Next-of-Kin)					
Relationship:	Phone:					
Address of emergency contact:						
- Autoria of Child	(If different than patient)	Street				
City	Province	Postal Code	Country	—		
- C.I.J						
RESIDENT / CITIZEN / IN	MIGRANT / VISA /	REFLIGEE				
☐ BC Resident		KEI JOLL				
Canadian Citizen	If less than 3 months, date arrived in BC:					
☐ Landed Immigrant	If landed immigrant or refugee, without a BC CareCard, OR on a visa,					
☐ Visa	please provide a photocopy of your immigration or visa paper.					
Refugee	If refugee, please provi	ide copies of both refugee docume	nts.			
INCUDANCE INCODMAT	ION					
INSURANCE INFORMAT	ION					
If WorkSafeBC (WSBC), please pr	rovide WSBC Claim Numb	er:				
If ICBC please provide ICBC Claim	n Number:					
ICBC Adjuster's name:						
Office:						
EXTENDED HEALTH CO	VERAGE / ACCOM	MODATION PREFEREN	CE			
Accommodation Preference:						
Standard ward -	No charge.					
☐ Private room / Private bath	\$ 195.00	Semi-private room	\$ 165.00			
— Private and semi-private rooms are	e subject to availability.	<u> </u>				
A deposit may be required for priva	•	requests. Prices are subject to cha	nge.			
Patient Signature:			Date :(dd/mmm/yyyy)			

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