PRE-ADMISSION INFORMATION

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 ☐ Married ☐ Separated ☐ Common-law ☐ Widow ☐ 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: Home: _____ Cellular: _____

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

City Province Postal Code Country

PLEASE COMPLETE THE BACK OF THIS FORM

PRE-ADMISSION INFORMATION

Please complete and return promptly

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) Home: _____

Cellular: _____

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: _____