

Please complete and return promptly.

ADMISSION INFORMATION

Site:

- Holy Family Hospital**
Admitting Department
7801 Argyle St
Vancouver, BC V5P 3L6
- St. Paul's Hospital**
Admitting Department
1081 Burrard St
Vancouver, BC V6Z 1Y6

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

Type of Admission:

- Inpatient
 Outpatient Clinic
 Surgical Short Stay
 Radiology
 Maternity
Expected date of delivery: _____

Expected Date of Admission / Visit: _____

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

If yes, what is the date of the most recent admission? _____

PERSONAL INFORMATION

Patient's Legal Name : _____
Last Name First Name Middle Name Previous Surname

Sex: Male Female **Date of Birth** Month / Day / Year): _____

Marital Status: Single Married Separated Widow
 Divorced Common-Law Companion Live-In

Religion: _____ **First Language Spoken:** _____

Personal Health Number (Care Card) / Medical Card Number: _____

Family Doctor: _____

Admitting Doctor / Surgeon / Obstetrician / Midwife: _____

ACCIDENT

Is this visit due to an accident? _____ 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

Phone: Home: _____ Work: _____ How long have you lived at the above address? _____

Previous Address: _____
(If less than 1 year) Street

City Province Postal Code Country

PLEASE COMPLETE THE BACK OF THIS FORM



PERSONS TO CONTACT

Legal Next of Kin: _____ **Relationship:** _____

Name (Spouse if married)

Address of next of kin (if different from patient): _____
 Street

_____ City Province Postal Code Country

Telephone number of next of kin (if different from patient): Home: _____ Work: _____

Emergency Contact (if different from next of kin): _____

Relationship: _____ **Phone:** _____

Address of contact: _____
 Street

_____ City Province Postal Code Country

RESIDENT / CITIZEN / IMMIGRANT / VISA / REFUGEE

BC Resident: Yes No **Canadian Citizen:** Yes No **Visa:** Yes No

Landed Immigrant: Yes No **Refugee:** Yes No

Date arrived in BC: _____ Date arrived in Canada: _____

If landed immigrant in Canada less than one year **OR** on a visa, please provide a photocopy of your immigration or visa paper. If refugee, please provide copies of both refugee documents.

EMPLOYMENT INFORMATION

Patient's occupation: _____ Employer: _____

Employer's address: _____

INSURANCE INFORMATION

If **WCB**, please provide WBC Claim Number: _____

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

ICBC Adjuster's name: _____ Office: _____

EXTENDED HEALTH COVERAGE / ACCOMODATION PREFERENCE

Do you have extended health benefits: Yes No If yes, what is your % coverage? _____

What is your deductible? _____ Insurance Plan: _____

Name of person insured (if not yourself): _____ Group / Policy Number: _____

_____ ID Number: _____

Many extended health benefits provide coverage for private and semi-private rooms. The hospital may be able to bill your plan directly.

A deposit is required for all private and semi-private room requests. Prices are subject to change.

Accommodation Preference:

Private room / Private Bath \$ 195.00 Semi-Private room \$ 165.00 Standard Ward No charge