

GRAND RIVER HOSPITAL

Childbirth Program

Pre-registration Forms

- Please read the attached information carefully
- Complete the forms prior to your baby's due date
- Bring the forms with you when you come to the hospital

GRAND RIVER
HOSPITAL
Advancing Exceptional Care



We are pleased that you have chosen to give birth at Grand River Hospital.

Over the course of your pregnancy you will have many questions. Between your health care providers, Waterloo Region Public Health and your community hospital, we'll do our best to answer those questions or to guide you to the most appropriate resources for your needs.

Before your first visit to the childbirth program, please complete the forms included in this package: pre-anesthetic form, standard pre-admission sheet and what you need to know. Be sure to also read "**choosing a hospital room after your baby is born**" before selecting your preferred accommodation.

Bring these completed forms, your Ontario Health Card and any additional insurance information when you come to the hospital. This will help to speed up your admission process.

All of these forms, along with other information about the childbirth program and the hospital can be found on our website: <http://www.grhosp.on.ca/Childbirth>

If you do not have access to a computer and/or printer, you may ask your health care provider for the forms.

As well, the Child and Family Health Department, Region of Waterloo, provides a range of programs and services to support expectant families. You can find more information about these services by calling the Healthy Children Information Line 519-883-2245 or by visiting their website: <http://chd.region.waterloo.on.ca/en/childfamilyhealth/beforethebabyisborn.asp>

We hope that this information is helpful and that your stay is as comfortable as possible.

Should you have any questions, please email us at childservices@grhosp.on.ca.

Choosing a hospital room

The childbirth program of Grand River Hospital's KW Site has three types of patient rooms available:

- Ward rooms (covered under OHIP);
- Semi-private rooms (\$275 per day); and
- Private rooms (\$320 per day).

Effective September 2020

Many patients have coverage for semi-private and private rooms through their extended health benefits. Please read carefully and speak with your insurance provider to understand what benefits you are entitled to. This may impact the accommodation you choose.

Please choose your preferred accommodation on the request section of the pre-admit form. We've included this form in your pre-admission package. When choosing a preferred room:

- Please find out your available coverage from your insurance carrier (EG: 100 per cent of the per-day rate, or a lesser amount). The benefit booklet supplied by your employer (or your partner's employer) may provide this information; or
- Check (✓) ward coverage if you are unsure or can't confirm your insurance coverage to make sure you're not unexpectedly billed.

During labour and birth, you'll have a private birthing room at no charge. After you give birth and until you're discharged from hospital, you may move to the room of your choice (depending on availability).

Starting one hour after the birth of your baby, you will be charged according to your preferred accommodation (ward, semi-private or private room), even if you remain in your birthing room.

If you are **hospitalized during your pregnancy,** you will be charged according to your preferred accommodation (ward, semi-private or private room).

If you have no insurance coverage but choose a private or semi room, the hospital will send you a bill for the room charges by mail after you're discharged. You may also receive a bill for any amount that your insurance won't pay such as a deductible.

When you're admitted, you can change your room coverage by completing a new pre-admit form. For example:

- If you confirm your insurance coverage before you come to the hospital and had earlier selected a ward room, we can upgrade your room after the birth of your child; or
- If you want to downgrade the room you will stay in after your child is born, we can accommodate you.

We will do our best to place you in the type of room you request as it becomes available. Given the high number of births at our hospital (over 4,300 babies every year) this may not always be possible.

If you require more information regarding your accommodations, please contact our patient accounts department at 519-749-4300 extension 2352.

Thank you.

ADMISSION FORM

Admit date: _____

- PLEASE NOTE:**
1. Surgical patients report to Ambulatory Registration. Bring Health Card to hospital.
 2. Obstetrical patients register at the Childbirth Unit on 4D North, any time of the day.

PATIENT'S PERSONAL INFORMATION

Last name		First name		Prior surname(s)/maiden name		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> _____	
Address			City		Postal Code		
Home phone #		Business phone # and ext.		May we use these numbers to contact you / leave a message? <input type="checkbox"/> No <input type="checkbox"/> Yes			
Family doctor		Surgeon		Allergies			
Age	Date of Birth year / month / day		Have you been a patient in any Health Care Facility for > 12 hrs in the last 12 months? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not interviewable				
Name of contact in case of emergency (spouse, parent, guardian, guarantor, etc.)						Relationship to patient	
Address <input type="checkbox"/> Same as above, or			Home phone		Business phone # and ext.		
Is this admission due to pregnancy? <input type="checkbox"/> No <input type="checkbox"/> Yes			E-mail address				
Please state which pregnancy this is:			Obstetrician / Midwife				

PATIENT RESPONSIBILITIES:

- I understand that I am responsible and liable for all the costs incurred during my or the below noted patient's stay which are not covered by valid Provincial Healthcare Insurance i.e. OHIP, I further agree to pay all additional charges on discharge.
- I understand that the hospital will bill my insurance company but that responsibility for full payment remains with me. It is my responsibility to verify my coverage with my Insurance carrier and Grand River Hospital assumes no responsibility for verifying my insurance coverage. I assign all benefits payable from my Insurance claim to Grand River Hospital.
- **I understand that in the event Grand River Hospital is unable to reach me following discharge due to invalid contact information i.e. Invalid address or phone changes that Grand River Hospital reserves the right to access this information via agencies.**
- If I request a private room but I am placed in semi-private, the cost for semi-private will be applied. Likewise, if I am placed in a private room while requesting a semi-private, the charges for semi-private will be applied.
- Any request to change your accommodation must be confirmed in writing, by contacting the Registration clerk.
- **I authorize Grand River Hospital to release information requested by my insurance company or agencies associated with the recovery of due funds.**
- **Rates are subject to change.**

Please check ONE box only:

1 st CHOICE	RATES	INITIALS	2 nd CHOICE	RATES	INITIALS
<input type="checkbox"/> WARD/ covered by Valid OHIP	NO CHARGE		<input type="checkbox"/> WARD/ covered by Valid OHIP	NO CHARGE	
<input type="checkbox"/> SEMI-PRIVATE	\$275/DAY		<input type="checkbox"/> SEMI-PRIVATE	\$275/DAY	
<input type="checkbox"/> PRIVATE	\$320/ DAY		<input type="checkbox"/> PRIVATE	\$320/DAY	

PLEASE SIGN FORM

Patient/ Guardian/ Substitute Decision Maker Signature: _____

Date _____ Name of Responsible Party / Patient or Policy Holder _____

Signature: _____

Interviewed by Staff Signature: _____ Staff Name: _____

Extension: _____

PLEASE SEE NEXT PAGE FOR INSURANCE DETAILS

HEALTH INSURANCE INFORMATION

Is the patient covered under Ontario Health Insurance Plan? <input type="checkbox"/> No <input type="checkbox"/> Yes Last name on Health Card:	Health Insurance Number	Version code
Do you have supplementary insurance for semi or private coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes PLEASE COMPLETE if you have supplementary insurance for all Day Surgery, Inpatient and Outpatient Procedures.		
If yes, name of insurance company	Policy, Group, or Contract #	
Certificate in name of <input type="checkbox"/> Patient <input type="checkbox"/> Other—please complete below	Certificate or I.D. #	
Name	Employer's name	
Relationship to patient	Employer's address	
Insurance coverage provided by employer <input type="checkbox"/> No <input type="checkbox"/> Yes	2 nd Policy, Group, or Contract #	
Employer's telephone number	Certificate or I.D. #	

WSIB INFORMATION	
Is this admission because of a work-related injury? <input type="checkbox"/> No <input type="checkbox"/> Yes—Employer's name _____	Date of injury year / month / day
Employer's address _____	Employer's telephone number () _____
If yes, claim number	Social Insurance Number

OUT OF PROVINCE INFORMATION	
Address of province of origin _____ _____ Home phone number () _____ Business phone number () _____	Is this: <input type="checkbox"/> Temporary move? <input type="checkbox"/> Permanent move?
	Provincial Health Care Number _____
	Expiry Date _____ Reason here <input type="checkbox"/> Vacation <input type="checkbox"/> Medical Referral <input type="checkbox"/> Temporary employment <input type="checkbox"/> Other _____
Is this admission the result of a motor vehicle accident? <input type="checkbox"/> No <input type="checkbox"/> Yes	

Method of Payment

CREDIT CARD INFORMATION — if OHIP or private insurance does not cover all charges, your credit card will be charged based on information completed below.	
<input type="checkbox"/> VISA <input type="checkbox"/> MASTERCARD	Name of card holder (please print) _____ Account number _____ Expiry date _____ Signature _____

ADMISSION MATERNAL-FETAL ASSESSMENT
CHILDBIRTH PROGRAM

Admission Date: _____ <small>year/month/day</small>		Time: _____
What languages do you speak?	What languages do you read?	Do you need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No
HISTORY		
How have you felt physically and emotionally during this pregnancy?		<input type="checkbox"/> Well <input type="checkbox"/> Other, comment
Medication: <input type="checkbox"/> No <input type="checkbox"/> Yes, specify		
<i>(Note: If patient taking prescription medication(s) or if this is an antenatal admission, complete BPMH in HED)</i>		
Alcohol Consumption/Street Drugs: <input type="checkbox"/> No <input type="checkbox"/> Yes, comment		
Did you smoke at any time during this pregnancy?	<input type="checkbox"/> No <input type="checkbox"/> 10-20 cigarettes/day	<input type="checkbox"/> less than 10 cigarettes/day <input type="checkbox"/> greater than 20 cigarettes/day
Did you live with a smoker at any time during this pregnancy?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you currently smoke?	<input type="checkbox"/> No <input type="checkbox"/> 10-20 cigarettes/day	<input type="checkbox"/> less than 10 cigarettes/day <input type="checkbox"/> greater than 20 cigarettes/day
Do you currently reside with a smoker?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Unknown
Would you like help with reducing/quitting?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
SPECIAL DIETARY REQUIREMENTS		
Do you have any food allergies or intolerances? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please specify which foods Describe how they affect you:		
Do you have any special dietary needs <input type="checkbox"/> No <input type="checkbox"/> Yes, If yes, what do you not eat?		
BIRTH PLAN		
Do you have any religious/cultural concerns or practices related to your pregnancy or the birth of your baby that you want us to know about to help with your care? <input type="checkbox"/> No <input type="checkbox"/> Yes, If yes, please explain		
Are preparations complete for your new baby?		<input type="checkbox"/> Yes <input type="checkbox"/> No, comment
Do you have any specific birth plan wishes?		<input type="checkbox"/> Yes, comment <input type="checkbox"/> No
Support person(s) in labour:		
Are you planning to breastfeed?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Did you breastfeed your other child(ren)?		<input type="checkbox"/> Yes, how long? _____ <input type="checkbox"/> No <input type="checkbox"/> N/A
Patient/Baby Safety: <input type="checkbox"/> Reviewed mom/baby safety information		
Nurse's signature: _____		

Preferred _____ Height: _____ Weight: _____ BMI: _____ Age: _____
 Name: _____ Lbs/kgs _____

Body System Review <i>(Do you have any of these medical conditions? Please check yes or no or circle, if appropriate)</i>		Yes	No	Any Comments
Heart and Circulation	High blood pressure			
	Heart attack Date: _____			
	Chest pains / Angina Frequency: _____			
	Heart murmur / Valvular heart disease / History of rheumatic fever			
	Blood clots DVT(legs) / PE(lungs) <i>(please circle)</i>			
	Congestive heart failure			
	Atrial fibrillation / Irregular pulse / Palpitations			
	History of angiogram / Stent insertion / Heart surgery <i>(please circle)</i>			
	Pacemaker or I.C.D. When Inserted: _____ Last Checked: _____			
	Peripheral vascular disease			
Respiratory / Lungs	Asthma, wheezing, chronic cough			
	Recent chest cold or pneumonia less than 1 month ago			
	Emphysema, COPD <input type="checkbox"/> Home Oxygen			
	Diagnosed or probable obstructive sleep apnea (OSA) <i>(breath-holding while asleep)</i>			
	• Regular CPAP machine use <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Activities limited by shortness of breath – stairs or walking one block			
	Emergency Department or ICU admission for breathing trouble (Lifetime)			
	Tuberculosis (T.B.) / Exposure			
	Have you ever smoked/Vaping <input type="checkbox"/> Yes <input type="checkbox"/> No Quit Date: _____ Currently smoke/Vaping? Packs per day average ___ Number of years ___			
Neurologic	Stroke or Transient Ischemic Attack (TIA) "mini-stroke" Deficits / Location: _____			
	Seizure / Epilepsy Date of last seizure: _____			
	Vertigo, balance disorders, headaches <i>(please circle)</i>			
	Neuromuscular disease (i.e. MS, CP, Myasthenia, ALS, Parkinson's) <i>(please circle)</i>			
	Paraplegia / Quadriplegia / Other mobility issues? <input type="checkbox"/> Wheelchair dependent			
Chronic pain syndrome Regular narcotic / opioid usage <input type="checkbox"/> Yes <input type="checkbox"/> No				
Endocrine	Diabetes Date Diagnosed: _____ <input type="checkbox"/> Diet <input type="checkbox"/> Pills <input type="checkbox"/> Insulin			
	Thyroid gland problems			
	Pituitary or adrenal gland disease			
	Autoimmune Disease (i.e. Sjogren's, Lupus, Psoriasis, Rheumatoid, Raynaud's) Recent steroid use (e.g. prednisone) Date: _____			
Gastro-intestinal / Renal	Kidney problems / Transplant / Dialysis PD / Hemo days: / /			
	Hepatitis / Liver disease / Jaundice			
	Acid reflux / Heartburn Treated with medications <input type="checkbox"/> Yes <input type="checkbox"/> No			
Other	Gout or Osteoarthritis <i>(please circle)</i> Location: _____			
	Mental health problems <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Other _____			
	Blood problems (i.e. Anemia / Low platelets / Sickle-cell disease / HIV)			
	Taking blood thinners – Reason: _____			
	History of cancer – Location: _____			
	Chemotherapy / Radiotherapy Date of treatment: _____			
	Glaucoma / Eye problems / Hearing loss <input type="checkbox"/> Glasses <input type="checkbox"/> Hearing aids			

Teeth: (please check) Own Wires Dentures Caps / Crowns Partial plate Loose / Poor condition

List all previous operations and approximate year: (Please attach list if space is insufficient)	
1.	4.
2.	5.
3.	6.

Have you ever been hospitalized for an illness not requiring surgery? Explain: _____

Do you have any health problems that need further explanation or testing? Explain: _____

Do you or your close relatives have a history of malignant hyperthermia (MH) or pseudocholinesterase deficiency? No Yes

Have you had a serious problem with previous anesthesia? (i.e. difficult intubation, vomiting, shivering, unplanned admission, post-operative confusion / delirium) No Yes

Explain: _____

Medications you are currently taking (please include over-the-counter, herbal and non-prescription meds)

Name of Medication (Please attach list if space is insufficient)	Dose (Amount)	Times of the day taken
1		
2		
3		
4		
5		
6		
7		
8		

Pharmacy Name: _____ Phone number: _____
 Pharmacy Location: _____

Medication Allergies (List drug name and reaction) (Please attach list if space is insufficient)

Drug	Reaction

Are you allergic to latex / rubber products? No Yes Reaction: _____

Lifestyle Choices	Yes	No
Do you drink alcohol regularly?		
• How many drinks / day? _____ or How many drinks / week? _____		
Have you ever taken street / recreational drugs? If currently, what? _____		
Explain if you have ever had problems with addictions		
Do you smoke marijuana? If YES, how much		
Have you ever received a blood transfusion?		
Would you <u>accept</u> a blood transfusion if deemed medically necessary?		

Procedure: _____ Patient's Signature: _____

Surgeon's Name: _____ Date: _____

Questionnaire completed by: _____ Relationship to patient: _____

AFFIX PATIENT LABEL	
Patient Name:	
DOB:	Gender:
OHIP:	
Phone #:	Alternate

Safety Pledge for Infants and Safe Sleep Practices

- ✓ I understand that the safest place for my baby to sleep is on their back in their crib, cot or isolette.
- ✓ I understand that there is a risk of suffocation, entrapment or falls associated with co-bedding (parent and child sharing the same bed) and that Grand River Hospital does not endorse co-bedding.
- ✓ I will let my nurse know if my baby was dropped or slipped to the floor even if he/she seems okay.
- ✓ I understand that the crib side rails or isolette door must be up and in a locked position when I am not able to give full attention to my baby.
- ✓ I understand that I must be within arm's reach of my infant if the isolette door is open or if the crib side rail is down.
- ✓ I will let my nurse know if I think that I am at risk of falling asleep when holding my baby.
- ✓ I will ask for help if I feel dizzy, weak, or am in severe pain before picking up my baby.
- ✓ I understand that I cannot walk outside of the patient room with my baby in my arms. If I must leave the room, my baby will be transported in a crib, bassinet, car seat, stroller, cot or I will be holding my baby in a wheelchair.
- ✓ I understand that there should not be any items in the crib with my baby (loose blankets, soft toys).

I confirm that I have reviewed the safety pledge for infants and safe sleep practices and will share this information with other individuals who may be involved with my infant.

Name: _____
(Print Name)

Relationship to Infant: _____

Signature: _____

Date: _____

Witness: _____



Patient belongings form

Dear patient/family member:

When admitted to hospital we strongly encourage patients to leave all valuables and other personal items not needed while hospitalized at home.

Grand River Hospital assumes no responsibility for patient possessions with the exception of articles secured in the cashier's office.

By signing this form, the patient/family/substitute decision maker (SDM) acknowledges that they have been informed of Grand River Hospital's policy regarding patient possessions.

I accept full responsibility for all items remaining with me now or brought into hospital during my stay.

Full printed name (patient/family/SDM)

Signature (patient/family/SDM)

Date

Relationship to patient

Witness (staff member)

Date

Personal items remaining with patient

PATIENT HAS	ON ADMISSION*	TRANSFER 1		TRANSFER 2		TRANSFER 3	
		TO	FROM	TO	FROM	TO	FROM
Dentures Lower							
Dentures Upper							
Hearing Aid Left/Right							
Glasses							
Other							

* For each patient move, staff receiving the patient must indicate transfer location, date, and initial in the appropriate space.

GRH STAFF: please indicate if the patient has stored items in the cashier's office:

YES NO

Grand River Hospital's Childbirth Program – What you need to know

1. Baby-Friendly Designation

Grand River Hospital has achieved a baby-friendly designation. This means that all staff who will be involved in your care have received training to assist you in breastfeeding your baby. Research shows that breastfeeding offers a number of health benefits for both mom and baby. Our staff will be glad to speak with you about breastfeeding and will support you – whether you choose to breastfeed or not.

2. Accommodations

Information about insurance coverage and room rates can be found on our website at www.grhosp.on.ca/childbirth_rooms.

3. Visiting Guidelines

General visiting hours are 7:30 am – 8:30 pm.

Visitors may stay beyond these hours – please speak to the patient's nurse about your request. For the privacy and safety of all our patients, visitors are not permitted to linger in unit hallways. Please make yourself comfortable in the patient's room or the family waiting areas.

For more information on visiting, visit www.grhosp.on.ca/childbirth-visiting

4. Doctors

We have a number of highly trained, respectful physicians who provide support to the childbirth program. Due to scheduling it is not possible to request a specific doctor or select the gender of your doctor.

5. Midwives

If you have chosen midwifery care, Grand River Hospital works collaboratively with four community midwifery practices.

6. Students

Grand River Hospital supports clinical education for the next generation of health care providers. At times, supervised medical and clinical students may be involved in your care.

7. Photography and Videotaping

Please ask before you click. Should you wish to take a picture or video while at the hospital please ask staff first. We are committed to respecting the privacy of those in hospital.

For further information please visit <http://www.grhosp.on.ca/Childbirth>