Grand River Hospital

Childbirth Program

Pre-registration Package

- 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 KW Campus
Childbirth Program 4th floor, D wing
835 King Street W, Kitchener Ontario
519 749 4300 extension 3865
info@grhosp.on.ca

GRAND RIVER HOSPITAL

Welcome to Grand River Hospital's Childbirth Program!

At Grand River Hospital (GRH), we view childbirth as a natural process and a normal life event. Our emphasis is on providing excellent patient and family-centred care, and our goal is for you to have a safe and satisfying experience.

Included in this pre-registration package is some information and important forms for you to complete before your first visit to the Childbirth Program.

When you come to the hospital, please bring a printed copy of your completed forms, your Ontario Health Card (if you have one), and any additional insurance information. If you are unable to print these forms yourself, you can ask your health care provider (doctor or midwife) for printed copies.

Questions? We are happy to help!

Please visit our website at **www.grhosp.on.ca/Childbirth** for information such as what to bring to the hospital and what to expect from your experience here.

If you have questions about your specific medical needs, we encourage you to discuss with your health care provider (doctor or midwife), or with our team when you arrive at the hospital.

Region of Waterloo Public Health is also an excellent source of information, resources, and services for families expecting a baby. Visit **www.RegionOfWaterloo.ca/HealthyPregnancy**, or call Public Health at 519-575-4400 to request information.

We hope this information is helpful and that your experience is positive. If you have questions, feel free to contact us: **info@grhosp.on.ca** or 519-749-4300 extension 3865.

GRAND RIVER HOSPITAL
Advancing Exceptional Care

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 ($300 per day from $290/day) as of July 15, 2022 ; and
- Private rooms ($350 per day from $340/day) as of July 15, 2022

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.

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PATIENT LABEL

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	❒ Male ❒ Female ❒ _____
Address	City	Postal Code	
Home phone #	Business phone # and ext.	May we use these numbers to contact you / leave a message? ❒ No ❒ 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? ❒ No ❒Yes _____ ❒ Not interviewable	
Name of contact in case of emergency (spouse, parent, guardian, guarantor, etc.)		Relationship to patient	
Address ❒ Same as above, or	Home phone	Business phone # and ext.	
Is this admission due to pregnancy? ❒ No ❒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:

1st CHOICE	RATES	INITIALS	2nd CHOICE	RATES	INITIALS
☐ WARD/ covered by Valid OHIP	NO CHARGE		☐ WARD/ covered by Valid OHIP	NO CHARGE	
☐ SEMI-PRIVATE	$300/DAY		☐ SEMI-PRIVATE	$300/DAY	
☐ PRIVATE	$350/ DAY		☐ PRIVATE	$350/DAY	

PLEASE SIGN and DATE BELOW

Patient/ Guardian/ Substitute Decision Maker Signature:

Date _____/_____/_____
Year / Month / Date

Name of Responsible Party / Patient or Policy Holder _____

Signature: _____

Interviewed by Staff Signature: _____ Staff Name: _____
Extension:_____

PLEASE SEE NEXT PAGE FOR INSURANCE DETAILS

SEE OVER →

GRAND RIVER HOSPITAL
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PATIENT LABEL

HEALTH INSURANCE INFORMATION

Is the patient covered under Ontario Health Insurance Plan? ❒ No ❒ Yes Last name on Health Card:	Health Insurance Number	Version code

Do you have supplementary insurance for semi or private coverage? ❒ No ❒ Yes
PLEASE COMPLETE if you have supplementary insurance for all Day Surgery, Inpatient and Outpatient Procedures.

If yes, name of 1st insurance company	1st Policy, Group, or Contract # :	1st Certificate or I.D. #:

Insurance Policy in name of ❒ Patient ❒ Other—please complete below

Name	Relationship to patient

Insurance coverage provided by employer ❒ No ❒ Yes	

Employer's name	Employer's address

2nd Insurance Company Name:	2nd Policy, Group, or Contract # :	2nd Certificate or I.D. #

2nd Insurance Policy in name of ❒ Patient ❒ Other	Name:	Relationship to patient

WSIB INFORMATION

Is this admission because of a work-related injury? ❒ No ❒ Yes—Employer's name _____ Employer's address _____	Date of injury year / month / day
	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: ❒ Temporary move? ❒ Permanent move?
	Provincial Health Care Number

Expiry Date _____	Reason here ❒ Vacation ❒ Medical Referral ❒ Temporary employment ❒ Other _____

Is this admission the result of a motor vehicle accident? ❒ No ❒ 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.

❒ VISA ❒ MASTERCARD	Name of card holder (please print) _____ Account number _____ Expiry date _____ **Signature** _____

GRAND RIVER HOSPITAL

ADMISSION PATIENT INFORMATION CHILDBIRTH PROGRAM

Admission Date: year/month/day	Time:	
What languages do you speak?	What languages do you read?	Do you need an interpreter? ❑ Yes ❑ No

HISTORY

How have you felt physically and emotionally during this pregnancy?

Do you take any medications (prescription or over-the-counter), vitamins, or supplements?: ❑ No ❑ Yes
If yes, please specify the name, dose, and times of day taken:

(Staff: complete BPMH in Cerner)

Alcohol Consumption/Street Drugs: ❑ No ❑ Yes, comment

Did you smoke at any time during this pregnancy? ❑ No ❑ less than 10 cigarettes/day ❑ 10-20 cigarettes/day ❑ greater than 20 cigarettes/day

Did you live with a smoker at any time during this pregnancy? ❑ Yes ❑ No

Do you currently smoke? ❑ No ❑ less than 10 cigarettes/day ❑ 10-20 cigarettes/day ❑ greater than 20 cigarettes/day

Do you currently reside with a smoker? ❑ Yes ❑ No ❑ Unknown

Would you like help with reducing/quitting? ❑ Yes ❑ No

SPECIAL DIETARY REQUIREMENTS

Do you have any food allergies or intolerances?
❑ No ❑ Yes If yes, please specify which foods and describe how they affect you:

Do you have any special dietary needs ❑ No ❑ Yes, If yes, please specify what you do 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? ❑ No ❑ Yes, If yes, please explain:

Are preparations complete for your new baby? ❑ Yes ❑ No, comment

Do you have any specific birth plan wishes? ❑ Yes, comment ❑ No

Support person(s) in labour:

Are you planning to breastfeed? ❑ Yes ❑ No

Did you breastfeed your other child(ren)? ❑ Yes, how long?_____ ❑ No ❑ N/A

Patient/Baby Safety: ❑ Reviewed patient/baby safety information

Nurse's signature:

GRAND RIVER HOSPITAL

PRE-ANESTHETIC QUESTIONNAIRE

St.Mary's GENERAL HOSPITAL

Patient Identification Label (Affix)

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

	Body System Review *(Do you have any of these medical conditions? Please check yes or no or circle, if appropriate)*	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) *(please circle)*			
	Congestive heart failure			
	Atrial fibrillation / Irregular pulse / Palpitations			
	History of angiogram / Stent insertion / Heart surgery *(please circle)*			
	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 □ Home Oxygen			
	Diagnosed or probable obstructive sleep apnea (OSA) (breath-holding while asleep)			
	• Regular CPAP machine use □ Yes □ 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 □ Yes □ 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 *(please circle)*			
	Neuromuscular disease (i.e. MS, CP, Myasthenia, ALS, Parkinson's) *(please circle)*			
	Paraplegia / Quadriplegia / Other mobility issues? □ Wheelchair dependent			
	Chronic pain syndrome Regular narcotic / opioid usage □ Yes □ No			
Endocrine	Diabetes Date Diagnosed: _____ □ Diet □ Pills □ 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 □ Yes □ No			
Other	Gout or Osteoarthritis *(please circle)* Location:_____			
	Mental health problems □ Depression □ Anxiety □ 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 □ Glasses □ Hearing aids			

See over →

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 accept a blood transfusion if deemed medically necessary?		

Procedure: _____ Patient's Signature: _____

Surgeon's Name: _____ Date: _____

Questionnaire completed by: _____ Relationship to patient: _____

GRAND RIVER HOSPITAL

AFFIX PATIENT LABEL

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: _____

GRAND RIVER HOSPITAL

AFFIX PATIENT LABEL

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

GRAND RIVER HOSPITAL

AFFIX PATIENT LABEL

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