Hamilton Health Sciences

EL 701051 (2017-08)

Requesting a Hospital Room

If you or your child are admitted as a patient at Hamilton Health Sciences (HHS), **you can request your choice of 3 types of patient rooms**:

1. Ward (3 or more beds) **covered by OHIP, no extra room charges**
2. Semi-Private (2 beds) **$ 275 a day**
3. Private (1 bed) **$ 310 a day**

Patients' medical needs are our first priority when assigning rooms. We will do our best to provide you a private or semi-private room if requested. If you wish a private room, please indicate your second choice as a private room may not be available when you or your child are admitted.

To complete your request, please fill out the "Preferred Accommodation Authorization Request" form

If you have any questions or concerns, please call:

Site →	General	Juravinski	MUMC	West Lincoln Memorial Hospital
	905-521-2100 Monday to Friday 7 a.m. to 3 p.m.	**905-521-2100** Monday to Friday 8:30 a.m. to 4:30 p.m.	**905-521-2100** Monday to Friday 8 a.m. to 4 p.m.	**905-945-2253** Monday to Friday 8 a.m. to 4 p.m.
Accommodations →	extension 46958	extension 43259	extension 75107	extension 280
Bed Booking →	extension 46233	extension 42242	extension 75106	extension 0

Requesting a semi-private or private room

- You will need to provide information about your extended insurance (either through your employer or private coverage). This will allow us to bill the insurance provider directly on your behalf.
- Any room charges not covered by your extended insurance will be the financial responsibility of the patient, guardian or patient's guarantor.
- To avoid any unexpected room charges, we strongly recommend that you contact your insurance provider before requesting a room. Confirm your insurance coverage and ask if you have a daily maximum, deductible or lifetime maximum. The hospital (HHS) is not responsible for confirming your insurance coverage.
- If you have no extended insurance and plan to pay for the room, we will need your credit card information and your signature on the Preferred Accommodation Authorization Request form.
- If you no longer want a private or semi-private room, it is your responsibility to contact the Registration Department. You will need to sign a new Preferred Accommodation Authorization Request form. You will be responsible for any charges up to that date.

Hamilton Health Sciences

Preoperative Patient Questionnaire - Adult

Patient's Last Name First Name

Address Street

City Province Postal Code

Health Card Number

Patient's Birthdate (yyyy/mm/dd) Age Sex ☐ M ☐ F

Date (yyyy/mm/dd)_____

Surgery_____

Name of person completing this form (if not the patient)_____

Relationship to patient_____

Name patient likes to be called:_____

Previous operations and / or hospital stays	Date (yyyy/mm/dd)	Previous operations and / or hospital stays	Date (yyyy/mm/dd)
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Have you ever had an anesthetic?	☐ No	☐ Yes
Have you had any problems with anesthesia such as unusual temperature changes or trouble breathing?	☐ No	☐ Yes
Do you have a blood relative who has had any problems with anesthesia such as unusual temperature changes or trouble breathing?	☐ No	☐ Yes
Mouth Do you have any loose teeth, capped teeth, braces or retainers?	☐ No	☐ Yes
Do you have dentures? ☐ No ☐ Yes → (Upper: ☐ Full ☐ Partial) ☐ Yes → (Lower: ☐ Full ☐ Partial)		
Do you have difficulty opening your mouth fully?	☐ No	☐ Yes
Do you have pain or difficulty when you move your neck?	☐ No	☐ Yes
Heart and Stroke Do you have high blood pressure or do you take medication for high blood pressure?	☐ No	☐ Yes
Do you have high cholesterol or do you take medication for high cholesterol?	☐ No	☐ Yes
Have you ever had angina or chest pain?	☐ No	☐ Yes
Have you ever had a heart attack?	☐ No	☐ Yes
Have you ever had heart failure?	☐ No	☐ Yes
Have you ever had an irregular heart beat?	☐ No	☐ Yes
Do you have a pacemaker or an implantable defibrillator?	☐ No	☐ Yes
Have you ever had a stroke or a mini stroke?	☐ No	☐ Yes
Have you ever had a blood clot?	☐ No	☐ Yes
Can you walk up two flights of stairs without stopping?	☐ No	☐ Yes

Patient's Last Name First Name

Hamilton Health Sciences

Preoperative Patient Questionnaire - Adult

Patient's Birthdate (yyyy/mm/dd) Age Sex ☐ M ☐ F

Date: (yyyy/mm/dd)_____

Breathing	Do you currently smoke? ☐ No ☐ Yes → Number of cigarettes a day ___ Number of years ___		
	Have you ever smoked? ☐ No ☐ Yes → When did you quit?_____ Number of cigarettes a day ___ Number of years ___		
	Do you have trouble with your breathing → During exercise? ☐ No ☐ Yes With normal activity? ☐ No ☐ Yes		
	Do you currently have a cough with mucous or sputum?	☐ No	☐ Yes
	Do you use oxygen at home?	☐ No	☐ Yes
	Do you snore loud enough to be heard from another room?	☐ No	☐ Yes
	Have you ever been told that you stop breathing while you are asleep?	☐ No	☐ Yes
	Have you ever been told that you have sleep apnea?	☐ No	☐ Yes
	Do you use a C-Pap or Bi-Pap machine regularly at home?	☐ No	☐ Yes
	Have you ever been told that you have asthma?	☐ No	☐ Yes
	Have you ever been told that you have tuberculosis, emphysema or chronic bronchitis?	☐ No	☐ Yes
Liver / Stomach	Have you ever been jaundiced (yellow colour of your skin)?	☐ No	☐ Yes
	Do you have frequent heartburn?	☐ No	☐ Yes
	Have you ever been told that you have a hiatus hernia?	☐ No	☐ Yes
	Have you ever been told that you have ulcers?	☐ No	☐ Yes
Renal / Endocrine	Do you have kidney disease?	☐ No	☐ Yes
	Do you have diabetes?	☐ No	☐ Yes
	Do you have thyroid problems?	☐ No	☐ Yes
Brain / Nerve	Have you ever been diagnosed with epilepsy, seizures or fainting spells?	☐ No	☐ Yes
	Do you have a disease that affects your muscles or nerves?	☐ No	☐ Yes
	Have you ever been treated for any mental illness?	☐ No	☐ Yes
Blood	Have you ever been told that you have a bleeding disorder?	☐ No	☐ Yes
	Have you ever been anemic or been told you have low iron?	☐ No	☐ Yes
	Have you ever had a blood transfusion?	☐ No	☐ Yes
	Would you have any objection to receiving blood products if necessary?	☐ No	☐ Yes
	Have you arranged with your surgeon's office to donate your own blood for surgery?	☐ No	☐ Yes

Hamilton Health Sciences

Patient's Last Name First Name

Preoperative Patient Questionnaire - Adult

Date: (yyyy/mm/dd)_____

Patient's Birthdate (yyyy/mm/dd) Age Sex ☐ M ☐ F

Infectious Disease	Have you ever been told you have HIV or AIDS?	☐ No	☐ Yes
	Have you ever been told you have hepatitis?	☐ No	☐ Yes
Other	Do you take prescription medication for chronic pain?	☐ No	☐ Yes
	Do you drink alcohol? ☐ No ☐ Yes → How many drinks per week _____		
	Do you use recreational or street drugs?	☐ No	☐ Yes
	Do you have any cultural or religious practices that we should be aware of while you are in the hospital?	☐ No	☐ Yes
Female Patients Only	Could you be pregnant at this time?	☐ No ☐ Yes	☐ N/A
	Date of last Menstrual period (yyyy/mm/dd) _____		

What other health issues should we be aware of before your surgery?

_____

_____

_____

_____

_____

_____

_____

Adult Preoperative Patient Questionnaire Reviewed By:

Printed Name	Signature & Designation	(yyyy / mm / dd)

Patient's Last Name First Name

Hamilton Health Sciences

Preoperative Patient Questionnaire - Adult

Pre Surgery Medication List

Patient's Birthdate (yyyy/mm/dd) Age Sex ☐ M ☐ F

Date: (yyyy/mm/dd)_____

Please list all medications you take including: • Prescription - including inhalers (puffers), insulin and patches • Vitamins / Supplements / Diet Pills • Herbal • Over the counter products • Eye / Ear drops • Nasal Mists	**Dose** (Strength)	**How Often Taken**	**When** Morning (am) Afternoon (aft) Evening (eve) Bedtime (pm)

Rx **Please bring all your prescription medication containers and non-prescription medication containers with you to the Pre-Op Clinic**



• including inhalers (puffers) and insulin •

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HAMILTON HEALTH SCIENCES
PRE-ADMISSION REGISTRATION

PLEASE PRINT CLEARLY - and return this form to the Admitting Department, prior to your admission

(Complete both sides of the form)

	Year	Month	Day
Date of Pre-op			
Date of Admission			
Maternity Due Date			

Have you been previously admitted to: ☐ Chedoke Campus ☐ General Campus ☐ Juravinski Campus ☐ McMaster University Medical Centre (MUMC) Campus

Patient Surname | Legal First | Middle

Alternate / Previous / OR Maiden Name | Legal First | **Date of Birth** Year Month Day | **Sex** ☐ Male ☐ Female

Home Address | Apartment or Unit Number

City | Province | Postal Code | **Home Phone** ( ) | **Business Phone** ( ) Ext:

Marital Status ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed ☐ Common-Law | **Language Preferred** Interpreter Services available in most languages upon request

Religion | **Do you wish a Clergy visit while a patient at the hospital** | **Do you wish to access the services of the Aboriginal Community Health Representative while a patient at the hospital?**

Health Insurance Card Number | Province | **Version Code** (If applicable) Letter(s) in corner of card | **Name as it appears on card**

Out of Country Insurance Company: Name | Address | Phone | **Contract Number**

PERSON TO NOTIFY IN CASE OF EMERGENCY

Surname First | **Relationship to Patient**

Address | Apartment Unit or Number

City | Province | Postal Code | **Home Phone** ( ) | **Business Phone** ( ) Ext:

NEXT OF KIN - Same as above ☐

Surname First | **Relationship to Patient**

Address | Apartment Unit or Number

City | Province | Postal Code | **Home Phone** ( ) | **Business Phone** ( ) Ext:

WORKERS SAFETY INSURANCE BOARD (WSIB) - If a WSIB case, please complete the following information:

Claim Number | **Social Insurance No.** | Employer at Time of Accident | Nature of Injury

Address | City | Province | Postal Code

Place of Accident | Date of Accident Year Month Day | Time of Accident

PHYSICIAN INFORMATION

Surgeon / Specialist Surname | Initials | **Family Physician:** / Surname | Initials

Address | City | Address | City

Province | Postal Code | **Phone** ( ) | Province | Postal Code | **Phone** ( )

Do you have any Medic Alerts?
(Conditions that the hospital should be aware of) ☐ **No** ☐ **Yes** (if Yes, specify) _____

Do you have any Food / Drug / Medication Allergies? ☐ **No** ☐ **Yes** (if Yes, specify) _____

Are you currently taking any medications (including prescribed, over-the-counter or herbal)? Please bring a list, including dosages with you.

Hamilton Health Sciences

Preferred Accommodation Authorization Request

Patient Accounts:

Hamilton Health Sciences 905-521-2100 ext 77000

West Lincoln Memorial Hospital Site 905-945-2253 ext 280

Patient Name

Street Address

City Province Postal Code

Patient Account Number

... MANDATORY ...

Country

If Patient is under 16 years of age, provide Guarantor information below

INSURANCE INFORMATION	1	2
Policy Holder Name		
Policy Holder Date of Birth		
Relationship to Subscriber		
Employer Name (former if retired)		
Insurance Company		
Policy / Group		
Cert / Identification Numbers		

Preferred Accommodation — **I accept financial responsibility for additional charges for preferred accommodation as indicated below for the period of hospitalization.**

Please Note: It is the patient's responsibility to know their insurance coverage for room accommodation.

Preferred Accommodation Charges

Please Check all that apply

- ☐ Private $ **310.00** each Day
- ☐ Semi-Private $ **275.00** each Day
- ☐ Standard Ward $ _____ each Day

Date: (Must be Indicated) _____

☐ In the event that a private room is not available, I request a semi-private room

IMPORTANT **Initials**

My initials indicate that it has been explained to me that I will be billed if my insurance company does not pay. _____

Standard Ward Accommodation (Basic) I accept financial responsibility for the basic Standard Ward accommodation charges for the above patient if the charges are not covered by the Ministry of Health or Workplace Safety & Insurance Board

WSIB Claim Number: _____ **Initials** _____

Assignment

- I hereby assign to Hamilton Health Sciences, all of the hospitalization benefits provided by my hospital insurance or so much thereof as may serve to satisfy my indebtedness, or that of my dependent to the Hospital, and I hereby authorize Hamilton Health Sciences to release the information for payment of the Hospital claim.
- I authorize my insurance company/ies to assign all payments directly to Hamilton Health Sciences, to cover all charges incurred for this period of hospitalization

Initials _____

Guarantor accepting financial responsibility MUST complete this section.

_____ X _____ _____

Printed Name → Patient (**or** Guarantor, if not the patient) **(MANDATORY)** Signature → Patient / Guarantor Phone Number

Guarantor Address: (Street, City, Province/ State, Postal Code/Zip Code, Country): _____

Payment Options: ***Payment is required before discharge, by, cheque, debit transaction or credit card.***

Note – Many supplementary insurance companies will NOT pay for Private or Semi-Private accommodation for WSIB

Comments:

HHS Witness: Printed Name: _____ Signature: _____ Ext: _____