Hamilton Health Sciences

Requesting a Hospital Room

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

Room Type	Number of Beds	Daily Charge
Ward	3 or more	Covered by OHIP – no charge
Semi-private	2	$275 per day
Private	1	$310 per 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. To make your request, please fill out 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.

If you have any questions, you can contact the preferred accommodation team by emailing PreferredAccommodation@HHSC.CA or by calling 905-521-2100 extension 75107.

Payment Information

- You will need to provide information about your insurance coverage if you would like us to bill the insurance provider directly on your behalf.
- Any room charges not covered by your 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. HHS is not responsible for confirming your insurance coverage.
- If you have no insurance and plan to pay for the room, we require your credit card information.

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.