BC WOMEN'S HOSPITAL+ HEALTH CENTRE
An agency of the Provincial Health Services Authority

PRE-REGISTRATION FORM

Please send with Antenatal Record Part 1 to BCW Admitting (Fax: 604-875-2971) ASAP after 12 weeks GA **(must be prior to 32 weeks)**

Note: This form contains private and confidential information. If you are not the intended recipient, please do not read it. Inform BCW at 604-875-2152 ASAP, then destroy it.

FOR COMPLETION BY PATIENT (Please complete this top section and return to your doctor or midwife)

* Fields marked by an asterisk **MUST** be completed in order for this pre-registration to be processed

Date your baby is due*:_____ Your family doctor:_____

The BCW doctor/midwife who will deliver your baby*: (if different than above)_____

Your Last Name*:_____ First Name and Initial*:_____
(as it appears on your Care Card)

Your Maiden Name (surname at birth):_____Your date of birth*:_____
(if applicable) (Year / Month / Day)

Current Permanent Home Address*:_____
(Street Address) (City or Town) (Postal Code)

Home/Cell Phone #:_____ Email Address:_____
(to be used only for the purposes of acknowledgment of your registration and provision of information resources)

Full name of spouse/partner/next of kin:_____ Relationship:_____

Their current address (if different from yours):_____ Phone #:_____

Citizenship*: ☐ Canadian Citizen ☐ Landed Immigrant ☐ Visitor ☐ Student/Work Visa ☐ Refugee

I have been living in Canada*: ☐ For more than 3 months ☐ For less than 3 months
(If less than 3 months in Canada, please attach a copy of immigration papers, passport, visa, order in council, etc)

My Canadian residency is*: ☐ Permanent ☐ Temporary, until _____

PHN / CARE Card Number*:_____ BCW Hospital Number:_____
(if available: found on Blue Card from previous visit to BCW)

Medical Insurance*: ☐ BC Medical Services Plan (MSP)
☐ Private Insurance / Self pay (must be resident; proof of address required)

FOR COMPLETION BY BCW PHYSICIAN OR MIDWIFE Office FAX#:_____

Application to Pre-Register For NON-Vancouver Patients (Check off all that apply)

☐ A long-term patient of mine (1 office visit, prior to start of this pregnancy)

☐ A long-term patient of my practice partner (1 office visit, prior to start of this pregnancy) Dr.'s Name:_____

x _____ signature of **BCW MD / RM** (primary care provider)

☐ Previously delivered at BCW, in: _____ (Year)

☐ A high-risk patient with significant maternal &/or fetal conditions requiring specialized care at BCW.

Risk Factors:_____
(please attach all available documentation for high risk applications: U/S, lab results/EMMA reports, consultant reports, etc.)

Case by case condition:_____

☐ Out-of-Vancouver exception

For Administrative Purposes Only: ☐ Accepted ☐ Not Accepted

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