ST JOSEPH'S HEALTH CENTRE TORONTO

BOOKING REQUEST

WTIS # _____

To be completed by Admitting Physician and forwarded to Booking Office

Name: LAST NAME FIRST NAME

Male ☐ Female ☐

J #: _____

DOB: _____

Address: _____

Telephone: _____

OHIP #: _____

PATIENT'S SURNAME: FIRST NAME: J#

ADDRESS:

CITY: PROVINCE: POSTAL CODE:

TELEPHONE NUMBERS: (PLEASE PROVIDE BOTH):
RES: BUS:

DATE OF BIRTH (DD/MM/YYYY): AGE: SEX: ☐ Male ☐ Female

INTERPRETER REQUIRED? ☐ NO ☐ YES LANGUAGE: ☐ AMERICAN SIGN LANGUAGE

FINANCIAL RESPONSIBILITY:

☐ OHIP PROVIDED HEALTH CARD #_____ VERSION CODE_____

☐ WSIB CLAIM # _____

☐ DELISTED OR COSMETIC PROCEDURES

☐ HOSPITAL PAYMENT COLLECTED AT DOCTOR'S OFFICE

☐ OTHER PROVINCE PROVINCIAL HEALTH INSURANCE # _____

☐ NON RESIDENT OF CANADA ☐ FINANCIAL ARRANGEMENTS MADE WITH SJHC

ADMITTING PHYSICIAN: _____

FAMILY PHYSICIAN:_____ TELEPHONE: _____

CHECK AS APPLICABLE

☐ ELECTIVE
☐ URGENT
☐ PEDIATRIC BED

LENGTH OF STAY

☐ SAME DAY DISCHARGE
☐ 1 NIGHT
☐ 2 NIGHTS
☐ 3 NIGHTS
☐ 4 NIGHTS
☐ 5 NIGHTS
☐ Expected L.O.S.

POST-OP REQUIREMENT

☐ CORONARY CARE UNIT
☐ ICU request form completed and faxed to ICU
☐ TELEMETRY
☐ PULSE OXIMETRY

PREFERENCE. LIST CODE #

DIAGNOSIS

PROCEDURE:

PROPOSED ANAESTHETIC:

☐ GENERAL ☐ SPINAL ☐ NEUROLEPT ☐ EPIDURAL ☐ LOCAL ☐ REGIONAL BLOCK ☐ LOCAL WITH GA STANDBY

ADMITTING DATE (DD/MM/YYYY)	DATE OF PROCEDURE (DD/MM/YYYY)	TIME OF PROCEDURE	TIME REQUIRED

SELECTIVE PRECAUTIONS / ISOLATIONS:

☐ PUL.TB ☐ MRSA ☐ VRE ☐ LATEX ALLERGY ☐ MALIGNANT HYPERTHERMIA ☐ OTHER

NAME OF PERSON TO NOTIFY / CONTACT: RELATIONSHIP: TELEPHONE:

PROSTHESIS **EXTERNAL** SPECIAL EQUIPMENT NEEDS:

PROSTHESIS **INTERNAL** SPECIAL EQUIPMENT NEEDS:

DATE (DD/Month/YYYY)	**Time (24 h)** _ _ : _ _ h	**SIGNATURE**	**PRINT NAME**