MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

Proud member of
East Toronto Health Partners

FAMILY BIRTHING CENTRE
PRE-ADMISSION REGISTRATION PACKAGE

Thank you for choosing Michael Garron Hospital (formerly Toronto East General Hospital) for your maternity and child birth education needs.

Please complete and return the attached forms:

- ☑ Pre-Admission Questionnaire
- ☑ Health Equity Questionnaire
- ☑ Request for Preferred Room Accommodation

Please bring the forms to the **Admitting Department** located on the 1st Floor, G-Wing. The department is open daily Monday to Sunday 7:30 am to 10:30 pm, including weekends and holidays.

You can also fax your forms to the Admitting Department at 416-469-7997.

IMPORTANT phone number: Family Birthing Centre Triage Nurse
416-469-6580 ext. 6216

Thank you.

(REV: NOVEMBER 2, 2021)

MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

FAMILY BIRTHING CENTRE
PRE-ADMISSION QUESTIONNAIRE

Patient ID Label

Please complete all five pages and print clearly.

FORM CPR-78 (REV. APR/20)

Welcome to Michael Garron Hospital. We are committed to the highest standards of patient care, teaching, kindness and respect. To prepare you for the upcoming birth of your baby, we ask that you please complete the following pre-admission questionnaire and request for room accommodation form carefully. Please return this questionnaire to the Family Birthing Centre reception desk (G Wing, 7th Floor) or afterhours to the Admitting Department (G Wing, 1st Floor). Your privacy to health information is of our upmost importance.

General Patient Information

Last Name: _____ (as written on Health card or official documents)

First Name: _____ (as written on Health card or official documents)

I prefer to be called:_____ I use the pronoun: ☐ He/him ☐Her/she ☐They/them

Date of Birth: MM/_____DD/_____YY/_____ Age_____ Your Baby's Due Date: MM/_____DD/_____YY/_____

Address: _____ Apt/Unit#_____

City:_____ Province:_____ Postal Code:_____

Home Phone: _____ Work: _____Other: _____

Email Address: _____ (for virtual consultation appointments)

OHIP/Provincial Health Card Number: _____ Expiry Date: MM/_____DD/_____YY/_____
Number Version Code

If you do not have a health card, what is your status? ☐Visiting Canada ☐Landed Status ☐Immigrant ☐Refugee

Do you require an Interpreter? ☐No ☐Yes - Specify language _____

If yes you require an interpreter, will someone be accompanying you to the hospital? ☐No ☐Yes

Practicing Religion: _____ *(We ask for your religion to identify specific requirements that may be necessary to follow during emergency situations or for your dietary and spiritual needs during your visit.)*

Do you have a family doctor? ☐No ☐Yes - Family Doctor's name:_____

Family Doctor's Address: _____Office Phone: _____

Who will be delivering your baby? ☐Obstetrician ☐Family Doctor ☐Midwife

What is the name of the person delivering you baby: _____

Insurance Information For Semi-Private & Private Room Accommodation Requests

Insurance Provider Name: _____ Group Number: _____ Policy Number: _____

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FAMILY BIRTHING CENTRE
PRE-ADMISSION
QUESTIONNAIRE

Patient ID Label

Please complete all five pages and print clearly.

Your Contact Person Information

Alternate Contact Person in case of emergency or if we are unable to contact the patient:

Name: Last: _____ First: _____

Relation to me: ☐Husband ☐Partner ☐Parent ☐Son ☐Daughter ☐Brother ☐Sister ☐Aunt ☐Uncle ☐Cousin ☐Grandparent ☐Friend ☐Other_____

Their address is: ☐same as mine. If not the same, their address and phone number is:

Address: _____ Apt/Unit#_____

City:_____ Province:_____ Postal Code:_____

Home Phone: _____ Work: _____Other: _____

Substitute Decision-Maker (SDM) for your care:

Name: Last: _____ First: _____

Relation to me: ☐Husband ☐Partner ☐Parent ☐Son ☐Daughter ☐Brother ☐Sister ☐Aunt ☐Uncle ☐Cousin ☐Grandparent ☐Power of Attorney (Personal Care) ☐Other _____

Their address is: ☐same as mine. If not the same, their address and phone number is:

Address: _____ Apt/Unit#_____

City:_____ Province:_____ Postal Code:_____

Home Phone: _____ Work: _____Other: _____

YOUR PRIVACY

We have an information pamphlet that explains what information we collect, how we use it and who we share it with. If you have any questions during your stay you can ask someone looking after you, or our privacy officer at privacy@tegh.on.ca or (416) 469-6580 x7781.

For Telephone & Visitor Inquires:
When you are in hospital anyone can call in and ask about you. We can only confirm that you are a patient and give your location (unit or room number). Your nurse can provide your general condition (good, fair) to the caller. Only this information is released to the public. **If you decide 'NO' that you do not want this information to be available, we will NOT be able to provide it to anyone whether they are calling or here visiting you, this includes your spouse, partner, family, friend, etc.**

Can we provide this information if someone calls in or visiting you? ☐YES ☐ NO

Please complete all five pages and print clearly.

Medical History

1. Do you have any Allergies: ☐ No ☐Yes - If yes, please list what you are allergic to and your reaction:
   _____
2. Have you ever had any problems with: ☐ sadness ☐eating ☐sleeping ☐anxiety ☐trauma ☐abuse ☐other (explain): _____
3. Have you ever been treated for depression or post-partum depression? ☐No ☐Yes
4. Would you like to speak to a Social Worker when you are admitted to the hospital? ☐No ☐Yes
5. Have you ever had a blood transfusion before? ☐No ☐Yes - If Yes why:_____
6. Do you have? ☐false teeth ☐caps ☐any loose teeth Also, do you have contact lenses? ☐No ☐Yes
8. My Height_____ Pre-pregnancy Weight_____ Current Weight _____
9. Number of previous pregnancies_____ Number of children _____ Age of children at home _____
10. Number of previous miscarriages/stillbirth/neonatal losses _____
11. Have you arranged care for your child(ren) while you are in the hospital? ☐No ☐Yes
    If No, please arrange for a responsible adult to care for your child(ren) while you are in hospital.
12. Number of Previous Cesarean Sections: _____ Number of Previous Vaginal Births: _____
13. Problems associated with this pregnancy (i.e. high blood pressure, diabetes, infections)?
    _____

Expectations for the Birth

1. Are you planning a vaginal birth? ☐No ☐Yes - **If No go to question seven (7)**
2. How do you cope with pain? (Select one) ☐Very well ☐Well ☐Not very well ☐Not at all
3. What strategies help you cope with pain?_____
4. How would you want to be supported during your labour and birth?
   ☐Bath/shower ☐Birthing ball ☐Ambulating ☐Breathing techniques ☐Music ☐Other: _____

   Important Note: *We strongly encourage you to practice supportive care in labour techniques prior to your hospital admission. Please call Toronto Public Health for more information on prenatal and postpartum services at 416-338-7600. We also provide Child Birth Education Classes.*
5. Are you considering medication for pain management? ☐No ☐Yes ☐ Undecided
6. Are you interested in having an epidural? ☐No ☐Yes ☐ Undecided
7. If you have had a Cesarean Section are you going to try to have a vaginal birth this time? ☐No ☐Yes
8. If you are planning to have another Cesarean Section, what is the reason?_____
   If this is your first birth experience, go to question eleven (11):
9. How was your last birth experience? Please explain_____
   _____
10. Did you Breastfeed (also referred to as chest feeding) your other child(ren)? ☐No ☐Yes - If Yes how long?____
11. How do you plan to feed this baby: ☐Breastfeeding ☐Combination (Breastfeeding and Formula) ☐Formula
    ☐Expressed Breast milk ☐Other: _____

Please complete all five pages and print clearly.

Social History

Please note some of these questions are sensitive. Your privacy is of upmost importance. Answering the following questions will enable us to provide individualized support and resources.

1. Will your partner be involved with your pregnancy/birth? ☐No ☐Yes ☐Undecided
2. Support person(s) in labour (list)_____
3. Do you have any help or support once your baby arrives? ☐Same as above ☐No help
   ☐Other: _____
4. Are there any foods you do not eat? ☐No ☐Yes - If yes, list the foods:_____
5. Do you feel you eat a healthy diet? ☐No ☐Yes
6. Do you exercise? ☐No ☐Yes - If yes what kind of activities:_____
7. Do you ever have difficulties making ends meet at the end of the month? ☐No ☐Yes ☐Prefer not to answer
8. Do you feel safe in your current living situation? ☐No ☐Yes
9. Do you plan on returning to your current living situation? ☐No ☐Yes
10. Have your ever been or are you currently being physically or emotionally abused? ☐No ☐Yes
    (Assaulted Women's Helpline, free at 1-866-863-0511)
11. Did you drink alcohol prior to pregnancy? ☐No ☐Yes - If yes, how many drinks per week:_____
12. Do you currently drink alcohol? ☐No ☐Yes - If yes, how many drinks per week:_____
13. Did you smoke prior to pregnancy? ☐No ☐Yes - If yes, when did you stop smoking:_____
14. Do you currently smoke cigarettes? ☐No ☐Yes - If yes, how many cigarettes per day:_____
15. Does anyone in your house smoke? ☐No ☐Yes
16. Do you or your partner use street drugs? ☐No ☐Yes - If yes, explain:_____
17. Are you a student? ☐No ☐Yes - If yes: High School☐ College☐ University☐ E.S.L. ☐
18. Do you plan to return to school? ☐No ☐Yes
19. Do you plan on taking prenatal classes? ☐No ☐Yes - If Yes, where are you taking prenatal classes?
    ☐Michael Garron Hospital ☐Other_____
20. Would you like to speak to a hospital Social Worker after your delivery who can help provide support and community resources? ☐No ☐Yes
21. Do you have any concerns about this pregnancy or the birth?_____

MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

HEALTH EQUITY QUESTIONNAIRE

We Ask Because We Care

We are collecting social information from patients to find out who we serve and what unique needs our patients have. We will also use this information to understand patient experiences and outcomes.

Do I have to answer all the questions?
No. The questions are voluntary and you can choose 'prefer not to answer' to any or all questions. This will not affect your care.

Who will see this information?
This information will be completely confidential. If used in research, this information will be combined with data from all other patients and no one will be able to identify any of the patients.

1. What language would you feel most comfortable speaking in with your healthcare provider?
Check ONE only.

☐ 1. Amharic	☐ 8. Dari	☐ 15. Italian	☐ 22. Russian	☐ 29. Tigrinya
☐ 2. Arabic	☐ 9. English	☐ 16. Karen	☐ 23. Serbian	☐ 30. Turkish
☐ 3. ASL	☐ 10. Farsi	☐ 17. Korean	☐ 24. Slovak	☐ 31. Twi
☐ 4. Bengali	☐ 11. French	☐ 18. Nepali	☐ 25. Somali	☐ 32. Ukrainian
☐ 5. Chinese (Cantonese)	☐ 12. Greek	☐ 19. Polish	☐ 26. Spanish	☐ 33. Urdu
☐ 6. Chinese (Mandarin)	☐ 13. Hindi	☐ 20. Portuguese	☐ 27. Tagalog	☐ 34. Vietnamese
☐ 7. Czech	☐ 14. Hungarian	☐ 21. Punjabi	☐ 28. Tamil	☐ 35. Other *(Please specify)*

☐ 88. Prefer not to answer ☐ 99. Do not know _____

2. Were you born in Canada?

☐ 1. Yes ☐ 2. No - If **NO**, what year did you arrive in Canada? ____ ☐ 88. Prefer not to answer ☐ 99. Do not know

3. Which of the following best describes your racial or ethnic group?
Check ONE only.

☐ 1. Asian- East (e.g. Chinese, Japanese, Korean)
☐ 2. Asian- South (e.g. Indian, Pakistani, Sri Lankan)
☐ 3. Asian- South East (e.g. Malaysian, Filipino, Vietnamese)
☐ 4. Black - African (e.g. Ghanaian, Kenyan, Somali)
☐ 5. Black - Caribbean (e.g. Barbadian, Jamaican)
☐ 6. Black - North American (e.g., Canadian, American)
☐ 7. First Nations
☐ 8. Indian - Caribbean (e.g. Guyanese with origins in India)
☐ 9. Indigenous/Aboriginal not included elsewhere
☐ 10. Inuit
☐ 11. Latin American (e.g. Argentinean, Chilean, Salvadoran)
☐ 12. Métis
☐ 13. Middle Eastern (e.g. Egyptian, Iranian, Lebanese)
☐ 14. White - European (e.g. English, Italian, Portuguese, Russian)
☐ 15. White - North American (e.g. Canadian, American)
☐ 16. Mixed heritage (e.g. Black- African & White-North American)
(Please specify) _____
☐ 17. Other(s) *(Please specify)* _____
☐ 88. Prefer not to answer
☐ 99. Do not know

4. Do you have any of the following?

Check ALL that apply.

☐ 1. Chronic illness
☐ 2. Developmental disability
☐ 3. Drug or alcohol dependence
☐ 4. Learning disability
☐ 5. Mental illness
☐ 6. Physical disability
☐ 7. Sensory disability (i.e. hearing or vision loss)
☐ 8. Other *(Please specify)* _____
☐ 9. None
☐ 88. Prefer not to answer
☐ 99. Do not know

5. What is your gender?

Check ONE only

☐ 1. Female
☐ 2. Intersex
☐ 3. Male
☐ 4. Trans- Female to Male
☐ 5. Trans- Male to Female
☐ 6. Other *(please specify)*_____
☐ 88. Prefer not to answer
☐ 99. Do not know

6. What is your sexual orientation?

Check ONE only

☐ 1. Bisexual
☐ 2. Gay
☐ 3. Heterosexual ("straight")
☐ 4. Lesbian
☐ 5. Queer
☐ 6. Two-Spirit
☐ 7.Other *(please specify)*_____
☐ 88. Prefer not to answer
☐ 99. Do not know

7. What was your total family income before taxes last year?

Check ONE only

☐ 1. $0 to $29,999
☐ 2. $30,000 to $59,999
☐ 3. $60,000 to $89,999
☐ 4. $90,000 to $119,999
☐ 5. $120,000 to $149,999
☐ 6. $150,000 or more
☐ 88. Prefer not to answer
☐ 99. Do not know

8. How many people does this income support? _____

☐ 88. Prefer not to answer
☐ 99. Do not know

Thank you for participating!

Ontario
Toronto Central Local Health Integration Network
Réseau local d'intégration des services de santé du Centre-Toronto

For more information, please visit the website - www.torontohealthequity.ca

MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

GUARANTEE OF PAYMENT AGREEMENT
FOR HOSPITAL VISIT/ADMISSION

Business Office at (416) 469-6580 ext. 6231

1. PATIENT INFORMATION:

PATIENT'S LAST NAME: _____ **FIRST NAME:** _____ **INITIAL:** **DATE OF BIRTH (MM/DD/YYYY):** _____

2. VISIT INFORMATION

DATE OF SERVICE: _____ **MRN:** _____ **EMERGENCY ENC:** _____ **INPATIENT ENC:** _____ **INPATIENT ROOM#:** _____

3. DEPOSIT FOR UNINSURED SERVICES WITH NO OHIP OR OTHER GOVERNMENT INSURANCE

IMPORTANT! **Uninsured patients are required to pay a minimum deposit**. The deposit does not include additional diagnostic test fees. Additional fees will be charged to the patient during or after the visit. The hospital charges exclude Specialist Physician fees. These fees are independently charged by the Physician(s).

Out-Patient Visit: Out-patient clinic = deposit of **$270.00** (excludes Physician fee which is paid directly to the Physician.)
Day procedure/tests = based on the type of service received (Business Office will provide fee amount)

Admission: **Two (2) day** room rate deposit is required for uninsured patients. The minimum deposit is **$ _____**

4. INPATIENT PREFERRED ROOM ACCOMMODATION

What is your first and second preferred room choice? (please initial in the boxes)

1ST Choice: INITIAL	*2ND Choice:* INITIAL	*Room Type:*		
		➔ Standard Ward Room:	3-4 Patients Per Room	- *Covered by OHIP/Government Insurance*
		➔ Semi-Private Room:	2 Patients Per Room	- Additional $ 250.00 per day
		➔ Private Room:	1 Patient Per Room	- Additional $ 295.00 per day
		➔ Deluxe Private Room:	1 Patient Per Room	- Additional $320.00 per day

➔

_____ _____ _____
NAME OF INSURANCE PROVIDER/COMPANY: **GROUP NUMBER:** **POLICY/CERTIFICATE/SUBSCRIBER NUMBER:**

RELATIONSHIP TO SUBSCRIBER:
➔ ❑SELF ❑PARENT ❑SPOUSE ❑OTHER:

➔ _____ _____
SUBSCRIBER'S SURNAME: **SUBSCRIBER'S GIVEN NAME:**

5. AUTHORIZATION FOR INSURANCE CLAIM

INITIAL ☐ I assign Michael Garron Hospital all hospital benefits payable from this claim or so much thereof as may serve to satisfy my indebtedness or that of my dependent. I authorize Michael Garron Hospital to release my information required to settle this claim to the above named insurer.

6. ACKNOWLEDGEMENT

- I agree to make a payment of **$ _____** dollars towards the account and I understand that this payment is a **deposit only.**
- I understand that I am responsible for paying <u>all</u> outstanding charges and I agree to pay the balance to Michael Garron Hospital.
- I understand that Michael Garron Hospital is not responsible for my personal effects that are lost, stolen or damaged.

My signature below indicates that I have read all the information on this form and understand my responsibilities and that of Michael Garron Hospital (formerly Toronto East General Hospital).

X _____ **X** _____ _____ _____
Signature of Patient | Signature of Guarantor | Date | Patient's Driver's License No.

X _____ _____ _____ _____
Signature of Witness (Staff) | **Print Guarantor's Name** | **Print Name of Interpreter** | **Guarantor's Driver's License No.**

7. CREDIT CARD PRE-AUTHORIZATION

I authorize Michael Garron Hospital to charge the total amount owning on my account for my hospitalization to this credit card.
CREDIT CARD: ❑ VISA ❑ MASTERCARD ❑ AMEX

_____ _____ _____ X_____ _____
CARD HOLDER NAME | **CREDIT CARD NUMBER** | **EXPIRY DATE (DD/MM/YY)** | **CARD HOLDER SIGNATURE** | **DATE**

IMPORTANT: ATTACH A COPY OF THE PATIENT'S & GUARANTOR'S PHOTO ID (i.e. DRIVER'S LICENSE, PASSPORT).

WHITE COPY - Business Office **YELLOW COPY** - Patient's Copy