Vancouver CoastalHealth
Promoting wellness. Ensuring care.
Providence HEALTH CARE
Provincial Health Services Authority
Province-wide solutions. Better health.

REGIONAL OR BOOKING FORM

Hospital Use Only *Required Fields - Bolded Sections*

Site: ______________________________

MRN	Acct #	Booking Form Received Date	ORMIS #

LEGAL SURNAME	**FIRST NAME**	**MIDDLE NAME**	**OR DATE**

PHN	Date of Birth (MM / DD / YYYY)	Gender ☐ M ☐ F

Address	City	Province	Postal Code	Country

Telephone Home	Work	Cell/Other	Local Contact Number

Preferred Method of Contact: ☐ Phone ☐ E-mail ☐ Mail ☐ Text Email:

Family Physician	Referral Date (MM / DD / YYYY)	First Consult Date (MM / DD / YYYY)	Ready to Treat Date (MM / DD / YYYY)
Referring Physician	Unavailable From (MM / DD / YYYY)	Unavailable To (MM / DD / YYYY)	Unavailable Reason

REFERRING PHYSICIAN
- ☐ Self-Referral
- ☐ Family Physician
- ☐ Surgeon same specialty as booking surgeon
- ☐ Surgeon different specialty as booking surgeon
- ☐ Other specialist

CANCER ☐ Not Suspected ☐ Suspected ☐ Proven
If cancer proven:
Has patient been assessed pre-operatively by a multi-disciplinary team? ☐ Yes ☐ No
Indicate clinical stage: ☐ I ☐ II ☐ III ☐ IV ☐ Not Known
Is this a recurrent cancer? ☐ **Yes** ☐ **No**

BILLING INFORMATION (If not MSP)
☐ WorkSafe BC ☐ ICBC ☐ Self ☐ Other Billing # / Information ______________

ADMISSION STATUS
- ☐ Surgical Day Care (SDC), Discharge Same Day (DSD)
- ☐ Day Surgery Short Stay (DSS) *(RH Only)*
- ☐ Admit Prior _____ days prior to OR date, **ELOS** _____ days
- ☐ Same Day Admit (SDA), **ELOS** _____ days
- ☐ Inpatient/Already in hospital

SPECIAL POST OP BED REQUIREMENTS
- ☐ ICU Bed ☐ NCCU *(LGH Only)*
- ☐ High Acuity Unit *(PHC Only)*
- ☐ Overnight Monitoring PAR *(PHC & VGH Only)*
- ☐ SOU Bed *(UBCH Only)*
- ☐ Special Care Unit *(VGH Only)* ______________

PROCEDURE CODE	**PROCEDURE** (Include Side)	**SURGEON**	**ASSISTANT**

Procedure Time (if not using booking system average time) ____________

DIAGNOSIS CODE

ANESTHESIA PREFERENCE
☐ General ☐ Epidural ☐ Spinal ☐ Local ☐ Sedation ☐ Regional Block ☐ Other ______________

PATIENT ALERTS/NOTES
- ☐ Blood Borne Infectious Disease
- ☐ BMI ≥ 35
- ☐ Diabetic Insulin Dependent
- ☐ Diabetic Non-insulin Dependent
- ☐ Difficult Airway (known)
- ☐ Latex Allergy
- ☐ MRSA / VRE (known)
- ☐ Obstructive Sleep Apnea
- ☐ Pacemaker / ICD
- ☐ Other ____________

☐ **No Blood Required**
BLOOD PRODUCTS
- ☐ Red Cell Request _____ Units
- ☐ Group and Screen
- ☐ Autologous Donor

} Attach signed Blood Consent and Pre-Printed Physicians Order forms

- ☐ Refused All Blood Products (Attach signed Refusal form)
- ☐ BUP Referral *(VA Only)*

OR REQUIREMENTS
Patient Position ______________
OR Table ☐ Basic
☐ Other ______________

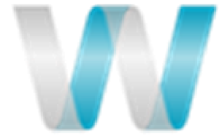
INTERPRETER
☐ Required, Language (specify): ______________

PRE-SURGICAL REQUIREMENTS
- ☐ Anesthesiology Consult – Reason ______________
- ☐ **Medical Consult (RH Only)** ______________

COMMENTS (Other OR requirements, equipment, special needs or pertinent physical/mental challenges) *(Coastal Only - Allergies)*

Gynecology Surgical Services

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



PATIENT INFORMATION

Surname: ______________________ First Name: _____________________
Email: _________________________ Preferred Contact #: _____________ Alternate #: _____________
Present Address: _______________________ City: ___________________________ Postal Code: _____________

Are you a Canadian citizen or permanent BC resident? ☐ YES ☐ NO

If **NO**, please check which applies to you: ☐ Visitor ☐ Student Visa ☐ Work Visa ☐ Refugee

If you have **non-MSP** health insurance (eg. private insurance from your employer, or from another province), please provide details of your insurance provider and policy number: ___________________________________

If you have been in BC less than 3 months, show date of arrival: ______________________(mm/dd/yyyy)

TO BE COMPLETED BY BOOKING OFFICE/OR BOOKING

PROCEDURAL SEDATION

☐ First available (pooled) ☐ Booking surgeon

☐ Approved by RN (initials) ______ ☐ Anesthesia consult required Consult date: _______________

Approved / declined by anesthesia (CIRCLE ONE, initials) ______ ☐ Surgeon's office notified _________

GENERAL GYNE OR

☐ Anesthesia consult required (TH/full consult) Consult date: ___________________________

☐ Internal medicine consult required Consult date: ___________________________

Approved / declined by anesthesia (CIRCLE ONE, initials) ______ ☐ Surgeon's office notified __________

ADDITIONAL RESULTS REQUIRED

____ ENDOMETRIAL BIOPSY within 6 months for all endometrial ablations
____ ULTRASOUND within 12 months for all myomectomies
____ HEMOGLOBIN within 3 months for all patients with menorrhagia having myomectomy or endometrial ablations

BC WOMEN'S HOSPITAL+ HEALTH CENTRE
Provincial Health Services Authority

BC Women's Hospital Surgical Services

Communicating by Email

You will be receiving an email from BC Women's Hospital with instructions regarding your upcoming surgery.

This will come from the email address: BCWHSSPC@cw.bc.ca

BC Women's Hospital (BCWH) offers patients the opportunity to receive communications by email. At times BCWH uses email to share information with patients. We will only share information with you by email if you give us permission to do so. Your health information is private and personal, and we want to ensure you understand how your privacy may be impacted by agreeing to email communication.

This email is **not for the purpose of providing individual patient medical advice**; if you have a specific medical problem or concern, **please contact your surgeon**, or if an emergency, attend your nearest emergency department.

It is important you understand:

- Once an email message is sent we can't guarantee who will be able to see it
- We will double-check that the email address you give us is correct but sometimes we may make a mistake and the message could be sent to the wrong person
- We recommend that you delete emails you get from BCWH. Sometimes, even if you delete emails, backup copies may exist on your computer or in cyberspace
- Someone could hack your email account and look at your private information
- We have no way of knowing if you read the email we sent to you
- It is your responsibility to let us know if you email address changes
- It is your responsibility to let us know if you no longer want to receive your information by email

If you have questions about this email, please call the Pre-Anesthesia Clinic at 604-875-2278 between 8:30am-4:30pm, Monday to Friday.

Please provide your email address below if you consent to email communication:

___________________________________ ________________

Email Address Date

☐ I do not have an email address

☐ I do not wish to receive emails from BC Women's Hospital

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

Place patient's hospital identification sticker here

Improving Surgical Outcomes following Gynecologic Procedures at BC Women's Hospital

PATIENT CONTACT INFORMATION COLLECTION FORM

Information for Patients:

BC Women's Hospital is evaluating a new way of following up with patients who have recently undergone a gynecologic procedure at the hospital. It is important for us to contact you once you have gone home from the hospital in order assess how you are recovering in the first few days following surgery, and to find out if you have developed any complications following your procedure. We would like to invite you to complete a short online survey which will allow us to assess symptoms following your surgery (e.g. nausea, pain), and any complications you may have developed following your surgery.

We would like to contact you to answer two online surveys; the first will be sent a few days after surgery and the second 30 days after your surgery. Your participation in these surveys is completely voluntary.

If you provide your email address below, we will send you a link to this survey by email. If you do not have an email address, please provide your phone number below and we will contact you by phone to ask you the survey questions.

Please note that the personal information collected through this form is collected in accordance with section 26(c) and (e) of the British Columbia Freedom of Information and Protection of Privacy Act, for the purpose of inviting you to participate in a survey that will assist us in evaluating our program of patient care. Your personal information will only be used by BC Women's Hospital for this purpose.

If you have any concerns, comments or questions about the survey and the collection and use of your personal information feel free to contact us at 604-875-2424 ext. 3671.

Contact information (required to send the online survey):

Surgeon________________________ **Date of Surgery (dd/mm/yyyy):** _______________

First name: _____________________ **Last name:**_________________________________

Email address: ____

If you do NOT have an email address, please provide your phone number.

Phone number: **(_____)** ________________________________

V3 2023.10.04

BC WOMEN'S HOSPITAL+ HEALTH CENTRE

BC Women's Hospital & Health Centre

CONSENT FORM

I, ______________________ (print name) ❑ Patient or ❑ Legal Representative agree to the following investigation, treatment or procedure ____________________________________

____

ordered by or performed by

____

❑ Physician ❑ Registered Midwife ❑ Nurse Practitioner ❑ Other_ (print name)

The nature and anticipated effect of the proposed investigation, treatment or procedure has been explained to me. In particular, I have been informed of the following:

- Diagnosis/condition,
- Purpose and nature of the investigation/treatment/procedure,
- Risks and benefits of the investigation/treatment/procedure,
- Alternatives to the proposed investigation/treatment/procedure,
- Likely consequences of not undertaking the investigation/treatment/procedure.

I have had the opportunity to ask questions. I am satisfied with the explanations and understand them.

I understand and agree that for the purpose of medical education and improvement of service there may be residents/students attending my treatment/procedure, either watching or participating

I agree that the health care provider named above may have other surgeons, physicians and hospital staff assist him or her and may permit them to order and/or perform all or part of my treatments, surgical operation or procedure. I also agree that these other health care providers may have the same discretion in my treatment, operation, or procedure as the provider named above.

I also consent to such additional or alternative investigations, treatments or procedures as in the opinion of the health care provider named above finds are immediately necessary.

______________________________ ______________________________

❑ Patient or ❑ Legal Representative (signature) Date (day/month/year)

______________________________ ______________________________

Witness (signature) (print name)

I hereby confirm that the above-named investigation, treatment or procedure falls within my scope of practice. I also confirm that I have explained the nature and effect of the investigation, treatment, or procedure to the person who signed the above consent form.

____

❑ Physician ❑ Registered Midwife ❑ Nurse Practitioner ❑ Other_

______________________________ ______________________________

(print name) Date (day/month/year)

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

CONSENT for

TRANSFUSION OF BLOOD and/or BLOOD PRODUCTS

1. Dr.________________________ has advised me that, in the course of my/my child's medical/surgical treatment, I/my child may need a transfusion of blood and/or blood products such as red blood cells, plasma, cryoprecipitate, factor concentrate, platelets, albumin or immunoglobulins.
2. I have been given information and have had the opportunity to ask questions about the benefits and risks of blood and/or blood products. I am satisfied that all my questions have been adequately answered. I understand what has been discussed.
3. Alternatives to transfusion have been discussed with me.
4. All blood donors are volunteers and are carefully screened by medical history and sensitive laboratory tests in order to minimize the risk of infectious disease transmission. Although the risk of infection or other adverse reaction from transfusion is very small, I understand that it is not possible to completely eliminate all risks of adverse reaction.

My signature below indicates that I consent to the transfusion of blood and/or blood products if it becomes necessary during the course of my treatment.

Special Instructions (if any – such as limitations to consent to include only specific blood products):

PATIENT / GUARDIAN

Name of Patient	Signature of Patient	Date

And/or

Name of person legally qualified to give consent	Signature of person legally qualified To give consent	Date
Relationship to patient		
Name of Witness to above signatures	Signature of Witness to above signature s	Date

PHYSICIAN

I have discussed the benefits and risks of planned or potential transfusion therapy with the patient or parent/guardian.

Name of Physician	Signature of Physician	Date

OR

We certify, due to the potentially urgent need for transfusion, the inability to obtain informed consent and the lack of advance directives indicating refusal of blood/blood products, we are unable to obtain informed consent prior to transfusion therapy.

Name of Physician	Signature of Physician	Date
Name of Physician	Signature of Physician	Date

This form will remain valid only for the duration of the treatment course.

C-0506-06-61129

Revised: September 1, 2000.

BC WOMEN'S HOSPITAL+ HEALTH CENTRE

BC Women's Hospital & Health Centre

CONSENT FORM

STATEMENT BY PROFESSIONAL INTERPRETER:

I have translated the information on this form to the ❑ Patient ❑ Legal Representative, and I have interpreted their responses to the Physician, Registered Midwife or Nurse Practitioner.

❑ In the presence of the patient _______ Professional Interpreter (signature) _______ (print name)

❑ Over the phone (witnessed) _______ Witness (signature) _______ (print name & designation)

Date signed by Interpreter or Witness: _______ (day/month/year)

Telephone Consent: Health Care

I have discussed the procedure outlined on the other side of this form and the anticipated effects of such investigation, treatment, or operative procedure, including the significant risks and alternatives outlined with

_______ who is the patient's (state relationship)

_______ , and he/she has given verbal consent for the procedure named above.

____

Time Date

_______ _______

Signature of Health Care Provider obtaining consent (print name)

_______ _______

Witness (signature) (print name)

BC WOMEN'S HOSPITAL+ HEALTH CENTRE

An agency of the Provincial Health Services Authority

PRE-ANESTHETIC QUESTIONNAIRE

Patient's Name: ____________________________ **Phone:** ____________________ **Email:** _____________________

Birth Date: _________________ **Age:**_____ **Weight:** ______**KG** **Height:** _____**CM** **BMI:** _______**kg/m^2**

PLEASE COMPLETE BOTH SIDES OF THIS FORM

This form will be submitted to the hospital as part of your confidential medical record, and will be viewed only by hospital physicians and nurses directly involved in your care.

Have you ever had any of the following?	NO	YES	If 'YES' to any of the questions, please provide details below
Life threatening problems with anesthesia? (include general anesthesia, epidural, spinal, nerve block, or local anesthesia)			Anesthesia Consult required
Blood related family member with life threatening problem with anesthesia?			Anesthesia Consult required
Regular tobacco smoker?			☐ Current cigarettes/day____ years _____ ☐ Past—year quit _______
Regular alcohol usage?			Type: _______________ amount/week ____
Regular recreational drug use?			Type: _______________ amount/week ____
Regular severe heartburn or acid reflux			Order ranitidine
Current difficulty opening your mouth of bending your neck?			
Do you have obstructive sleep apnea?			☐ CPAP machine at home ☐ Sleep study? When/Where: ___________
Shortness of breath with normal activity such as walking or climbing stairs?			If **'YES'**, please state how many: Blocks you can walk without stopping _______ Flights of stairs _______
Do you have ☐ Asthma ? ☐ Emphysema/COPD?			If **'YES'**, any attacks in the past 3 months?
Irregular heartbeats or palpitations?			☐ Atrial fibrillation ☐ Other:_________
High blood pressure?			
Heart related chest pain or angina?			Heart attack ? ☐ No ☐ Yes: When?______
Heart surgery: ☐ bypass ☐ angioplasty ☐ pacemaker			Year:_____________ Hospital: ____________
Heart murmur or heart valve problems?			☐ Echocardiogram: when/where___________________________

Have you ever had any of the following?	NO	YES	If 'YES' to any of the questions, please provide details below
In the past 5 years, have you been seen by a **cardiologist** or had any of the following tests? Exercise stress test (treadmill test)? Nuclear medicine heart scan (MIBI)? Heart catheterization (angiogram)? Echocardiogram (heart ultrasound)?			Cardiologist name: ______________________ When/where: __________________________ When/where: __________________________ When/where: __________________________ When/where: __________________________
Stroke or transient ischemic attack (warning stroke)?			When: ______________________________
Spinal cord injury OR surgery?			Paraplegic / Quadriplegic level: ______ Spine surgery / level:_____________________
Epilepsy / seizures?			Date of last seizure: ____________________
Diabetes ? ☐ Diet controlled ☐ Pills ☐ Insulin			
Liver problems, jaundice, hepatitis?			When: ______________________________
Kidney problems?			☐ Dialysis ☐ Kidney transplant
Bleeding disorders or clotting problems?			☐ Hemophilia ☐ VonWillebrands Disease
Blood borne or other infectious diseases?			Details: _____________________________
Refusal to receive blood products?			☐ Jehovah's Witness
Rheumatoid arthritis?			

Medications (including doses):

____

____

____

____

____

If on **pain medication**, please indicate the maximum dose that you have taken on **ONE DAY** in the past month.

☐ This space is insufficient, a separate list of medications is attached

Medication Allergies (include reaction):

____

____

____

____

LATEX: ☐ **Contact** ☐ **Anaphylaxis**

IV contrast/iodine: ☐ **NO** ☐ **YES** _____________

Do you speak conversational English? ☐ YES ☐ NO If 'NO', what language do you speak?

OBSTRUCTIVE SLEEP APNEA ASSESSMENT

- ☐ Do you snore loudly?
- ☐ Are you more tired during the day than you think you should be?
- ☐ Do you have high blood pressure?
- ☐ Are you older than 50 years old?
- ☐ Do you have a wide neck (more than 40cm)?
- ☐ Have you been told that you sometimes stop breathing when you snore?
- ☐ Is your BMI** greater than 35?

**Calculate BMI by dividing your weight in kg by your height in metres squared e.g. kg/M^2

STOPBANG SCORE (1 point for each 'YES' answer): ________

*** score ≥ 5 indicates likely moderate/severe sleep apnea**

My signature authorizes BC Women's Hospital to access my personal health information recorded elsewhere, for the purpose of providing medical care. This includes access to my **PharmaNet** medication profile and **Pathnet** laboratory information (Lifelabs).

__________________ __________________________ ____

Date authorized **Patient Name (print)** **Patient Signature**

Gynecology Surgical Services

ARRIVAL INFORMATION

Your procedure date:

____

Your hospital arrival time:
___________________am/pm

Traffic/parking can be challenging

Please leave ample time to arrive on time

THINGS YOU SHOULD KNOW...

- Bring your BC Care Card and 1 piece of ID
- If you are not fluent in English, let us know so that we can arrange a translator
- Take medications with a sip of water on the day of surgery
- Leave all valuables and money at home

QUESTIONS??

Phone
604.875.2985

Email
BCWHSSbooking@phsa.ca

BC WOMEN'S HOSPITAL+ HEALTH CENTRE

PATIENT PRE-OPERATIVE INSTRUCTIONS

- If you are **unwell** (fever, cold, flu) in the days prior to surgery, please advise your surgeon as soon as possible; it is preferable to **reschedule your procedure for when you are healthy**
- You will need to have someone to take you home after surgery
- You must to have someone stay with you overnight on the day of your surgery
- You cannot drive for 24 hours after surgery
- If you live outside of the lower mainland, please make plans to stay in the lower mainland for at least 24 hours following surgery

DIRECTIONS TO SURGICAL SUITES

BC Women's Hospital Entrance #93

- Entrance #93 is easiest to access via Willow Street
- Enter through the sliding doors and proceed to the
- left, past the circular Registration Desk
- Follow overhead signs toward **SURGICAL SUITES**
- Turn right when you come to the end of this curved connector hallway.
- Make a left turn under the **SURGICAL SUITES** sign