

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