## **HOSPITAL REGISTRATION NON-SURGICAL BOOKING FORM**

## PATIENT IDENTIFICATION

		學報節		
HOTEL DIEU HOSPITAL	KINGSTON GENERAL HOSPITAL	[PAR25]		
☐ IMAGING SERVICES	☐ IMAGING SERVICES	(ADDRESS)		
☐ ENDOSCOPY HDH	☐ OPPU			
☐ G.I. FUNCTION	☐ ENDOSCOPY KGH	BINTHDATE WYYY UND		
L C.I. TONOTION	☐ INPATIENT NON-SURGICAL	PHONE		
×	ELECTIVE URGENT  Expected length of stay			
*	Expected length of stay			
l	Transferred from			
SEBVICE.	Date: (YYYY/MM/DD)		MODIC BUONE NO	ALTERNATE BUONE NO
SERVICE	ATTENDING DOCTOR	HOME PHONE NO.	WORK PHONE NO.	ALTERNATE PHONE NO
FAMILY DOCTOR	REFERRING DOCTOR	REFERRAL DATE	WSIB Related?	☐ Yes ☐ No
Diagnosis Procedure Name:  Physician(s):				
Name:				
Physician(s):		Time	Required	
Name:			70- 30- 30-	
Urgency Scoring  INDICATIONS FOR BOWEL PREP TYPE  ADVERSE REACTIONS	1 2 3 4 OR Surv Req ENDOSCOPY: PF E:	veillance Scoring Suested date for procedure FD CN SA	e	r code explanation  (Y / MM / DD  erse for code explanation
		Family MD		
	Morbid Obesity   No Known	TO SERVICE STATE OF SERVICE STATE OF SERVICE S		
	STING REQUIRED: No C			
	EQUIRED: No Yes Film L			
	INSTRUMENTATION OR EQUIPME			
		manufacture and the same		Ĵ
PRINTED	NAME	PHYSICIAN'S SIGNATURE	DATE	E&TIME (YYYY/MM/DD HHMM
	HNH FORWARD TO DEPARTMENT	FOR PROCEDURES AT KO		
FOR PROCEDURES AT	HUH EURWARII IO DEPARTMENT	FUR PRUCEDIDES AT KO	H CHILDATIENT EO	DIMADD TO ODDII

FOR PROCEDURES AT KGH INPATIENT, FORWARD TO ADMITTING

## **HISTORY & PHYSICAL EXAMINATION**

CR # NAME: PATIENT IDENTIFICATION

(PLEASE PRINT)

	-
ADVERSE REACTIONS (including latex & dyes)	

ADDRESS:

BIRTHDATE: (YYYY / MM / DD)

PHONE:

## PLEASE FOLD BACK OTHER PARTS BEFORE WRITING ON THIS SIDE

PLEASE COMPLETE ALL SECTIONS OF THIS FORM.

HISTORY (RELEVANT MEDICAL/SURGICAL/FAMILY HISTORY)

SYSTEMS REVIEW				
NO YES  Diabetes Smoker Asthma / COPD / dyspnea	Details of "yes" answers	or other		
☐ ☐ Angina / Chest Pain / M.I. ☐ ☐ Edema / Orthopnea				
☐ ☐ Hypertension ☐ ☐ Syncope / Seizures / TIA's				
<ul><li>☐ Bleeding Problems</li><li>☐ G.I. Problems</li><li>☐ G.U. Problems</li></ul>				
MEDICATIONS (include prescription and over-the-	counter medications)			
9				
PHYSICAL EXAMINATION				
HT: cm WT: kg BP: HR:	TEMP: °C			
TICK IF NORMAL  Head & Neck				
☐ Chest				
		100		
CVS				
□ CVS            □ Abdomen				
Abdomen			¥	
Abdomen  Neuro / Extremities  Genitourinary / Breast				
Abdomen  Neuro / Extremities				
Abdomen  Neuro / Extremities  Genitourinary / Breast			· · · · · · · · · · · · · · · · · · ·	

PRINTED NAME

PHYSICIAN'S SIGNATURE

DATE & TIME (YYYY/MM/DD HHMM) OFFICE PHONE NUMBER