# Non-Surgical Registration Booking Form

**Hospital Identification**

<table>
<thead>
<tr>
<th>Hotel Dieu Hospital</th>
<th>Kingston General Hospital</th>
</tr>
</thead>
</table>

**Services**

- Imaging Services
- Endoscopy HDH
- G.I. Function

**Patient Identification**

- Name:
- Address:
- Birth Date (YYYY/MM/DD):
- Phone:

**Expected Length of Stay**

- Days:
- Date (YYYY/MM/DD):

<table>
<thead>
<tr>
<th>Service</th>
<th>Attending Doctor</th>
<th>Home Phone No.</th>
<th>Work Phone No.</th>
<th>Alternate Phone No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Doctor</td>
<td>Referring Doctor</td>
<td>Referral Date</td>
<td>WSIB Related?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Procedure 1**

- Diagnosis:
- Procedure Name:
- Physician(s):
- Time Required:

**Procedure 2**

- Diagnosis:
- Procedure Name:
- Physician(s):
- Time Required:

**Indications for Endoscopy**

- Bowel Prep Type:
  - PF
  - FD
  - CN
  - SA
  - OS

**Adverse Reactions**

**Procedural Sedation**

- No
- Yes

**History & Physical Complete**

- Attached
- On patient record

**Patient Alerts**

- Latex Allergy
- Pacemaker/ICD
- Diabetes
- Anticoagulant
- Morbid Obesity
- No Known

**Pre-Procedural Testing Required**

- No
- Yes

**External X-rays Required**

- No
- Yes

**Comments / Special Instrumentation or Equipment Required**

**Printed Name**

**Physician's Signature**

**Date & Time (YYYY/MM/DD)**

FOR PROCEDURES AT HDH, FORWARD TO DEPARTMENT

FOR PROCEDURES AT KGH OUTPATIENT, FORWARD TO OPPU

FOR PROCEDURES AT KGH INPATIENT, FORWARD TO ADMITTING

**Distribution:**

1. Chart Copy
2. Physician's Copy
3. Department Booking / History & Physical
HISTORY & PHYSICAL EXAMINATION

ADVERSE REACTIONS (including latex & dyes)

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
☐ Angina / Chest Pain / M.I.
☐ Edema / Orthopnea
☐ Hypertension
☐ Syncope / Seizures / TIA’s
☐ Bleeding Problems
☐ G.I. Problems
☐ G.U. Problems

MEDICATIONS (include prescription and over-the-counter medications)

Details of “yes” answers or other

PHYSICAL EXAMINATION

HT: cm  WT: kg  BP: HR: TEMP: °C

TICK IF NORMAL

☐ Head & Neck
☐ Chest
☐ CVS
☐ Abdomen
☐ Neuro / Extremities
☐ Genitourinary / Breast

IMPRESSION / SUMMARY

PRINTED NAME

PHYSICIAN'S SIGNATURE

DATE & TIME (YYYY/MM/DD HH:MM)

OFFICE PHONE NUMBER

HOSPITAL REGISTRATION /