

## 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

For Administrative Purposes Only:

☐ Accepted ☐ Not Accepted

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