HOSPITAL REGISTRATION
NON-SURGICAL BOOKING FORM

HOTEL DIEU HOSPITAL

- ☐ IMAGING SERVICES
- ☐ ENDOSCOPY HDH
- ☐ G.I. FUNCTION

KGH KINGSTON GENERAL HOSPITAL

- ☐ IMAGING SERVICES
- ☐ OPPU
- ☐ ENDOSCOPY KGH
- ☐ INPATIENT NON-SURGICAL
  - ☐ ELECTIVE ☐ URGENT

Expected length of stay _____ days

Transferred from _____

Date: (YYYY/MM/DD) _____

PATIENT IDENTIFICATION

OR #

NAME:

ADDRESS:

BIRTHDATE: (YYYY / MM / DD)

PHONE:

SERVICE	ATTENDING DOCTOR	HOME PHONE NO.	WORK PHONE NO.	ALTERNATE PHONE NO.
FAMILY DOCTOR	REFERRING DOCTOR	REFERRAL DATE	WSIB Related? ☐ Yes ☐ No	

PROCEDURE 1

Diagnosis _____

Procedure Name: _____

Physician(s): _____ Time Required _____

PROCEDURE 2

Diagnosis _____

Procedure Name: _____

Physician(s): _____ Time Required _____

COMPLETE FOR ALL ENDOSCOPY CASES

Urgency Scoring 1 2 3 4 OR **Surveillance Scoring** S _____ see reverse for code explanation

Requested date for procedure _____ YYYY / MM / DD

INDICATIONS FOR ENDOSCOPY: ☐ PF ☐ FD ☐ CN ☐ SA ☐ OS see reverse for code explanation

BOWEL PREP TYPE:

ADVERSE REACTIONS _____

PROCEDURAL SEDATION ☐ No ☐ Yes Anesthesiologist required? ☐ No ☐ Yes

HISTORY & PHYSICAL COMPLETE: ☐ Attached ☐ On patient record

If incomplete, to be completed by: ☐ Attending MD ☐ Family MD

PATIENT ALERTS ☐ Latex Allergy ☐ Pacemaker/ICD ☐ Diabetes ☐ Anticoagulant _____
☐ Morbid Obesity ☐ No Known

PRE-PROCEDURE TESTING REQUIRED: ☐ No ☐ Yes Completed Date: (YYYY/MM/DD) _____ ☐ Orders Attached

☐ TEST(S) TO BE DONE DAY OF PROCEDURE _____

EXTERNAL X-RAYS REQUIRED: ☐ No ☐ Yes Film Location: _____

COMMENTS / SPECIAL INSTRUMENTATION OR EQUIPMENT REQUIRED _____

PRINTED NAME _____ PHYSICIAN'S SIGNATURE _____ DATE & TIME (YYYY / MM / DD HHMM) _____

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)

PATIENT IDENTIFICATION
(PLEASE PRINT)

CR #
NAME:

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		Details of "yes" answers or other
☐	☐	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)

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 HHMM) | OFFICE PHONE NUMBER