MATERNITY ADMISSION INFORMATION

FULL LEGAL NAME:			
PREVIOUS NAME:		DATE OF BIRTH (DD-MMM-YYYY):	
PERSONAL HEALTH NUMBER (CARE CARD #):			
FAMILY PHYSICIAN:		MATERNITY PHYSICIAN/MIDWIFE:	
MATERNITY DUE DATE: (DD-MMM-YYYY):			
PLANNED SITE OF BIRTH: ☐ VGH ☐ LADY MINTO ☐ HOME		IF AT HOME, BACKUP HOSPITAL: ☐ VGH ☐ LADY MINTO	
CURRENT RESIDENTIAL & MAILING ADDRESS: STREET:			
CITY:	PROVINCE:	POSTAL CODE:	
PHONE: HOME	WORK	CELL	LENGTH OF RESIDENCE:
LOCAL ADDRESS IF OUT OF COUNTRY/PROVINCE:		PHONE:	
PREVIOUS RESIDENTIAL ADDRESS (IF AT CURRENT LESS THAN 6 MONTHS):		LENGTH OF RESIDENCE (6 MONTHS TOTAL RESIDENCE REQUIRED):	
NEXT OF KIN: RELATIONSHIP:		NAME:	
ADDRESS:		CITY:	PROV:
PHONE HOME:	PHONE WORK:	CELL PHONE:	
EMERGENCY CONTACT PERSON: RELATIONSHIP:		NAME:	
ADDRESS:		CITY:	PROV:
PHONE HOME:	PHONE WORK:	CELL PHONE:	
HOW LONG HAVE YOU LIVED IN BC?			
ARE YOU A CANADIAN CITIZEN?	☐ YES ☐ NO IF NO, ARE YOU:	☐ LANDED IMMIGRANT **PHOTOCOPY REQUIRED IF LESS THAN 1 YEAR** ☐ ON VISA (TYPE: WORK, TRAVEL, STUDENT, ETC.) **PHOTOCOPY REQUIRED**	
ADMISSION INFORMATION - PLEASE RETURN TO:		ADMITTING DEPARTMENT VICTORIA GENERAL HOSPITAL 1 HOSPITAL WAY, VICTORIA BC V8Z 6R5 PHONE: 250-727-4158 FAX: 250-727-4032	

Are you interested in requesting a private room: ☐ Yes

A private room costs $xxx per day (2021 rates; subject to change). Most Extended Health plans cover some or all of the cost.
(By answering YES, you are giving Island Health permission to call you regarding the Preferred Accommodation Program)