Homewood Health Centre

PATIENT INFORMATION FORM

Proud to be smoke-free tobacco-free

You have been referred for admission to Homewood Health Centre. To prepare for your arrival, we need some information from you. If you are unable to complete this form by yourself, you can ask a friend or relative to help you complete it, or you may phone Homewood's Admitting Department for assistance.

Please complete this form in black ink and return it to: **Admitting Department**
150 Delhi Street, Guelph ON N1E 6K9
Fax: 519.767.3533 **Email:** admit@homewoodhealth.com
Phone: 519.767.3550

PATIENT CONTACT INFORMATION (please provide telephone number(s) where messages can be left)

Title: _____ Last Name: _____ Given Name: _____

Preferred Name: _____ Middle Name: _____ Alias: _____

Maiden Name: _____ Mother's Maiden Name: _____ Gender: _____

Address: _____ ❑ Transient

City: _____ Province/State: _____ Postal/Zip Code: _____ Country: _____

Phone: _____ Business Phone: _____ Ext: _____ Mobile phone: _____

Email: _____ Date of Birth: _____

Preferred method of contact: ❑ Phone ❑ Email

Health card number: _____ Version code: _____ Issuing Province: _____

Health card name (if different from above): _____ OR reason for no HC#: _____

EMERGENCY CONTACT INFORMATION (please provide telephone number(s) where messages can be left)

Name: _____ Relationship to Patient: _____

Address (if different from above): _____ City: _____

Province/State: _____ Postal/Zip Code: _____ Country: _____

Phone: _____ Business/Alternate Phone: _____ Email: _____

SECOND EMERGENCY CONTACT INFORMATION (please provide telephone number(s) where messages can be left)

Name: _____ Relationship to Patient: _____

Address (if different from above): _____ City: _____

Province/State: _____ Postal/Zip Code: _____ Country: _____

Phone: _____ Business/Alternate Phone: _____ Email: _____

REFERRAL SOURCE CONTACT INFORMATON

Name of Referring Physician or Clinician: _____

Name of Disability Case Worker: _____

Family Physician: _____ Address: _____

Phone: _____

What type of accommodation are you requesting? ❑ Ward ❑ Semi-Private ❑ Private

Reason for admission: _____

PATIENT INFORMATION

Do you have a history of setting fires? ❑ Yes ❑ No

Are you currently involved in a clinical drug study/trial? ❑ Yes ❑ No If Yes, explain: _____

Are you aware that some programs require supervised urine testing (as per program policies)? ❑ Yes ❑ No

Are you coming for treatment because of a court order? ❑ Yes ❑ No

Will you be bringing your vehicle for paid parking? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No

Please list any allergies (e.g., medication, foods, insects): _____

_____

Marital Status: ❑ Single (never married) ❑ Married ❑ Common Law ❑ Divorced ❑ Separated ❑ Widowed

With whom are you currently living? _____

Do you have children? ❑ Yes ❑ No If Yes, please complete the following:

Name	Age	Quality of Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Education:
❑ College (completed) ❑ University (BA Level) ❑ University (MA, PhD)
❑ University/College (partial) ❑ Secondary (completed) ❑ Secondary (partial)
❑ Technical/Trade school ❑ Elementary (grade 8 or less) ❑ Unknown

Employment status:
❑ Full-time employment ❑ Part-time employment ❑ Employment Insurance
❑ Retired ❑ Disability assistance (private) ❑ Homemaker
❑ Student/Retraining ❑ Unemployed seeking work ❑ Unemployed not seeking work
❑ Ont. Disability Support Prgm (ODSP) ❑ Guaranteed Income (pensions) ❑ Unknown Financial Status
❑ Family support/inheritance ❑ Social Assistance ❑ Other (investment/student loan)
❑ Disabled ❑ No income ❑ Other

If you are not working, when were you last employed? _____

Occupation: _____ Employer: _____

Employer's Address: _____ Phone: _____

Source of income: ❑ Employed ❑ Social assistance ❑ Other income ❑ No income ❑ Employment Insurance ❑ Pension ❑ Disability Insurance

Height: _____ Weight: _____ Are you of Aboriginal Origin? ❑ First Nation ❑ Inuit ❑ Métis ❑ Not Aboriginal ❑ Unknown ❑ Not Applicable

Are you fluent in English ❑ Yes ❑ No ❑ Other preferred language: _____

Do you have difficulty reading? ❑ Yes ❑ No Do you have difficulty writing? ❑ Yes ❑ No

Please indicate any religious beliefs or practices that may affect your treatment: _____

Do you smoke? ❑ Yes ❑ No

Have you ever received a pneumonia vaccination? ❑ Yes ❑ No If Yes, please provide date (YYYY-MM-DD): _____

Date of last flu shot (YYYY-MM-DD): _____

Do you have any history of self-harm (cutting, burning, etc.)? ❑ Yes ❑ No Past suicide attempts? ❑ Yes ❑ No

Additional comments: _____

_____

_____

PROSTHETICS/MOBILITY

❑ Prosthetic leg
❑ Prosthetic arm
❑ Lower Denture
❑ Upper Denture
❑ Partial Bridge
❑ Other needs _____

❑ Glasses
❑ Contacts
❑ Hearing problems
❑ Hearing aids
❑ CPAP machine

❑ No problem walking
❑ Mobility aids (wheelchair, cane, walker, scooter, crutches)
❑ Transfer assistance needed
❑ Vision problems

Do you require a service animal? ❑ Yes ❑ No

DISCHARGE PLANNING

After discharge, would you have concerns about any of the following? (Check all that apply.)

❑ Child care issues ❑ Personal safety ❑ Crisis support ❑ Support for activities of daily living

PRIOR ADMISSIONS, CURRENT OUT-PATIENT SERVICES, ACTIVE SELF-HELP GROUPS

Please list any admissions to Homewood and/or other psychiatric or addiction facilities:

Year admitted: _____ Facility: _____ Length of Stay: _____

Year admitted: _____ Facility: _____ Length of Stay: _____

Year admitted: _____ Facility: _____ Length of Stay: _____

Year admitted: _____ Facility: _____ Length of Stay: _____

Number of admissions to Homewood: _____ Number of admissions to other facilities: _____

Are you currently using any out-patient services? ❑ Yes ❑ No If Yes, please provide details:

Name of Service: _____

Contact: _____ Telephone: _____

Name of Service: _____

Contact: _____ Telephone: _____

Name of Service: _____

Contact: _____ Telephone: _____

Are you currently participating in any self-help groups? ❑ Yes ❑ No If Yes, please list: _____

_____

PHARMACY INFORMATION

Pharmacy Name: _____ Address: _____

City: _____ Province/State: _____ Postal/Zip Code: _____

Country: _____ Phone: _____

Have you used another pharmacy in the last year? ❑ Yes ❑ No ❑ Unknown

DRUG PLAN INFORMATION

Do you have a drug plan? ❑ Yes ❑ No If No, how do you currently pay for drugs? _____

Please note: for ODSP, Trillium and other Ontario Government social service programs, there is an online list that your Homewood doctor can consult to ensure the prescribed medications are covered.

BILLING

If you are requesting semi-private or private accommodation, please complete this section:

Are you self-paying for your accommodation? ❑ Yes ❑ No

If you are self-paying (in part or in whole), please indicate the method of payment:

❑ Cash ❑ Major Credit Card ❑ Cheque

If you are not self-paying, please provide the following information:

Name of Payer: _____ Address: _____

City: _____ Province/State: _____ Postal/Zip Code: _____

Country: _____ Phone: _____

Please note: *30 days' payment is due on the date of admission. Please refer to financial information provided by the Admitting Department.*

INSURANCE INFORMATION ***(Note: an employee number is mandatory for all Chrysler Corporation patients requesting payment through insurance)***

Primary Insurer:

Name of Insurance Company: _____ Employee Number: _____

Group Policy Number: _____ I.D. or Certificate Number: _____

Subscriber's Name: _____ Subscriber's Date of Birth (YYYY-MM-DD): _____

Subscriber's Employer: _____ Employer's Phone Number: _____

Employer's Address (if different from above): _____ City: _____

Province/State: _____ Postal/Zip Code: _____ Country: _____

Patient's Relationship to Policy Holder: ❑ Holder ❑ Spouse ❑ Dependant ❑ Student (full-time) ❑ Student (part-time)

Secondary Insurer:

Name of Insurance Company: _____ Employee Number: _____

Group Policy Number: _____ I.D. or Certificate Number: _____

Subscriber's Name: _____ Subscriber's Date of Birth (YYYY-MM-DD): _____

Subscriber's Employer: _____ Employer's Phone Number: _____

Employer's Address (if different from above): _____ City: _____

Province/State: _____ Postal/Zip Code: _____ Country: _____

Patient's Relationship to Policy Holder: ❑ Holder ❑ Spouse ❑ Dependant ❑ Student (full-time) ❑ Student (part-time)

Although you may have semi-private or private coverage, you should be aware that some insurance companies do not cover accommodation at Homewood Health Centre Inc. To avoid unexpected charges, we strongly suggest that you obtain written verification that your insurance company will cover the cost of your stay at Homewood prior to admission. Please note: you are responsible for payment of your semi-private or private accommodation if your insurance company does not cover the cost.

Please ask your insurance company the following questions:

1. *Does my insurance cover the cost of semi-private or private accommodation for mental illness/addiction treatment at Homewood Health Centre Inc.?*
2. *What is the maximum amount of money or maximum length of stay covered by my insurance?*

Our practice with some insurance companies is to email information for verification. Please contact us if you are not in agreement with this process. Please sign below authorizing Homewood to verify the accuracy of the above insurance information with your insurance company and/or employer (Note: when verifying this information with the insurance company, it may be necessary to share the reason for admission.)

Name of Employer: _____ Name of Insurance Company: _____

Signature: _____ Date: _____

Homewood is compliant with current privacy legislation. Homewood collects personal information for assessment and treatment, as well as for operational and organizational, research and teaching, and legal and regulatory purposes. For questions or concerns contact the Privacy Office at privacy@homewoodhealth.com or 519.824.1010, extension 2443.