Homewood Health Centre

Patient Information Form

Reset Form

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**
Phone: 519.824.1010 **Fax:** 519.767.3533 **Email:** admit@homewoodhealth.com

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

Today's Date:	Title:	Last Name:		Given Name:
Preferred Name:		Middle Name:		Alias:
Preferred Pronouns:	Gender Identity:	Biological Sex:		Date of Birth:
Address: ☐ No current address				City:
Province/State:	Postal/Zip Code:			Country:
Home Phone:	Business Phone:		Ext:	Cell phone:
Email:	Preferred Method of Contact: ☐ Home Phone ☐ Cell Phone ☐ Email			
Health Card Number:	Version Code:	Issuing Province:		
Health Card Name (if different from above):	or reason for no HC#:			

TREATMENT PROVIDER INFORMATION

Referring Physician/Clinician:	Disability Case Worker:
Family Physician:	Phone:
Address:	

PATIENT INFORMATION

What type of accommodation are you requesting? ☐ Ward ☐ Semi-Private ☐ Private			
Why have you been referred for a Homewood admission?			
For this admission to be successful, what do you want to see happen or change?			
Please list any allergies (e.g., medication, foods, insects):			
Are you pregnant?	☐ Yes ☐ No	If yes, when are you due:	
Are you currently involved in a clinical drug study/trial?	☐ Yes ☐ No	If yes, explain:	
Have you had a flu shot in the last year?	☐ Yes ☐ No	If yes, please bring documentation of this	
Your height:	Your weight:		

SAFETY QUESTIONS

Do you have a history of:					
☐ Yes	☐ No	Falling?	☐ Yes	☐ No	Suicide attempts?
☐ Yes	☐ No	Fire setting?	☐ Yes	☐ No	Violence towards property?
☐ Yes	☐ No	Self-harm (e.g. cutting, burning, etc.)	☐ Yes	☐ No	Violence towards others?
☐ Yes	☐ No	Sexual aggression?	☐ Yes	☐ No	Wandering or leaving hospital without permission?
☐ No	☐ Yes	Currently are you able to maintain the safety of yourself and others in an unlocked hospital setting without constant supervision?			
Additional comments:					

GROUP READINESS AND FUNCTIONING

☐ No	☐ Yes	Are you fluent in English?	If no, other preferred language:
☐ Yes	☐ No	Are you limited in your ability to walk? If yes, you may wish to bring a cane, walker, wheelchair or electric wheelchair.	
☐ Yes	☐ No	Do you require our assistance to participate in group programming due to significant limitation of your vision or hearing?	How can we help?
☐ Yes	☐ No	Do you plan to bring a service animal?	

SUBSTANCE USE HISTORY

☐ No	☐ Yes	Some Homewood programs require supervised urine drug testing. Do you agree to urine drug testing if ordered by the Homewood physician?	
☐ Yes	☐ No	Do you use tobacco products (e.g. smoke)?	
☐ Yes	☐ No	Do you use medical marijuana?	
☐ Yes	☐ No	Do you take methadone? If yes, amount used daily:	For ☐ addiction or ☐ chronic pain
☐ Yes	☐ No	Do you take suboxone? If yes, amount used daily:	For ☐ addiction or ☐ chronic pain
☐ Yes	☐ No	Do you use alcohol or any addictive substance? If yes, please fil out the following table:	

	Date of last use?	**Amount used per day?**		**Date of last use?**	**Amount used per day?**
Alcohol			Opiates		
Cocaine			Other:		
Marijuana			Other:		

LEGAL QUESTIONS

☐ Yes	☐ No	Are you facing any criminal charges currently?	If yes, please describe:
☐ Yes	☐ No	Is your treatment court mandated (required by a court order)?	
☐ Yes	☐ No	Do you have any upcoming court appearances scheduled to testify, defend against charges or receive sentencing?	If yes, when?
☐ Yes	☐ No	Are you currently on probation?	
☐ Yes	☐ No	Have you ever been found NCR (Not Criminally Responsible)?	
☐ Yes	☐ No	Do you have a criminal record?	Please describe:

PAST ADMISSIONS

☐ Yes ☐ No Have you had a previous admission to Homewood and/or other psychiatric or addiction facilities?		
If yes, please list any admissions:		
Year Admitted:	**Facility:**	**Length of Stay:**
Number of admissions to Homewood:	Number of admissions to other facilities:	

CURRENT TREATMENT

Are you currently using any out-patient services? ☐ Yes ☐ No If yes, please provide details:		
Name of Service:	Contact:	Telephone:
If yes, please list:		
Are you currently participating in any self-help groups? ☐ Yes ☐ No		

CURRENT EMPLOYER

Name:		Phone Number:
Address:		City:
Province/State:	Postal/Zip Code:	Country:

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

Name:		Relationship to Patient:
Address:		City:
Province/State:	Postal/Zip Code:	Country:
Phone:	Alternate Phone:	Email:

NEXT OF KIN CONTACT INFORMATION Please provide telephone number(s) where messages can be left

☐ Same as above, if not complete below:

Name:		Relationship to Patient:
Address:		City:
Province/State:	Postal/Zip Code:	Country:
Phone:	Alternate Phone:	Email:

PHARMACY INFORMATION

Pharmacy Name:		Phone:
Address:		City:
Province/State:	Postal/Zip Code:	Country:
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:		Phone:
Address:		City:
Province/State:	Postal/Zip Code:	Country:

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

INSURANCE INFORMATION

Note: Please forward a copy of your benefit card.

Primary Insurer:

Name of Insurance Company:		Employee Number:
Group Policy Number:		I.D. or Certificate Number:
Subscriber's Name:		Subscriber's Date of Birth:
Subscriber's Address (if different):		City:
Province/State:	Postal/Zip Code:	Country:
Subscriber's Employer:		Subscriber's Phone Number:
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:
Subscriber's Address (if different):		City:
Province/State:	Postal/Zip Code:	Country:
Subscriber's Employer:		Subscriber's Phone Number:
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).*

Signature:	Date:

Please note that Homewood Health offers a comprehensive continuum of care that focuses on mental health and addiction inpatient and outpatient treatment. If one of our services beyond the Homewood Health Centre is deemed beneficial to meet your needs, we will have intake from the appropriate Homewood Health service connect with you about all Homewood Health has to offer.

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 32443.

Homewood Health Centre

Version: *August 19, 2020*

Treatment at Homewood Health Centre during COVID-19

The health, safety and wellbeing of our patients, staff and volunteers is Homewood Health's priority. We have put the following measures in place for everyone's protection.

14 DAY ADMISSION RESTRICTIONS:

- You will be given a wristband to wear **at all times** for your first 14 days of treatment
- During this time, you will not be able to use the Recreation Centre, fitness or yoga rooms, gymnasium, Library or patient dining room **except** during scheduled program use (Horticulture Therapy, Creative Arts, Recreation Therapy in the gymnasium etc.)
- Your meals will be delivered to your unit for you to eat in your room or in your unit's common area

MASK USE:

- You are required to **wear a mask at all times** throughout your admission (including when you are in our fitness and yoga room)
- The only exceptions are:
    - When you are outside on the grounds **and** are able to physically distance from others by at least two meters (six feet)
    - When you are in your own room **and** are able to physically distance from your roommate (if applicable), and when you are asleep

GROUNDS PRIVILEGES:

- You are limited to grounds privileges only which mean that **you are not to leave Homewood's property for the duration of your admission**
- Doing so may result in your immediate discharge

VISITORS:

- You may designate **one** visitor (over the age of 18) **for the duration of your admission**
    - This person will remain your designated visitor throughout your treatment; your designated visitor **cannot be changed**
- Visitors will be scheduled for pre-arranged, one hour visiting time slots on dedicated days
    - **We are not able to accommodate last minute visits or "walk-ins"**
- Scheduled, one-hour visits will take place **on the unit only**
- The visitor will be asked to show photo ID at the entrance and will be screened, including a temperature reading, before they enter for each visit
- You and your visitor **must be wearing masks throughout the visit**
- Physical distancing (six feet/two meters apart) must be maintained **at all times**, including between you and your visitor
- Any packages being brought in by visitors will be checked to ensure contents comply with our safety policies
- A reminder that **outside of scheduled visits with your designated visitor, there are still no unscheduled visits permitted**. An unscheduled visit is any in-person interaction (regardless of whether any physical contact is made) with someone who is not currently on active duty affiliated with the work of Homewood, is not a current patient admitted to or actively participating in the services of Homewood, and is not your designated visitor during an on-unit, scheduled visit. **If you are in breach of Homewood's visitor policy you may have your 14 day admission restrictions re-started** (if applicable), restricted to your unit and discharge may be considered.

PACKAGE DELIVERIES:

- You are asked to limit your package deliveries to four (4) deliveries per admission
- Packages are processed by our loading dock Monday to Friday – you will not be able to retrieve your package directly from the loading dock
- **All packages delivered will be opened under supervision of a staff member** to ensure the contents are complying with our safety policies

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DROP OFF OF ITEMS:

- Your friends and family are able to **drop off items for you to a member of our screening team** via the Delhi Street entrance
- You parcel will then be kept in a locker until you and a member of your care team can retrieve it and checked to ensure the contents are complying with our safety policies
- **A reminder that <u>this is not an opportunity to visit</u>** and doing so will be considered a breach of our visitor policy

FOOD DELIVERIES:

- If you order food to the Health Centre via a delivery service, please **pre-pay, wear your mask** when you retrieve your food and **maintain physical distance** from the delivery person
- Your food deliveries may be inspected at the discretion of your care team

OFFSITE APPOINTMENTS:

- If you are approved to leave Homewood grounds for an appointment offsite (i.e. a medical appointment), you will need to **wear a mask**
- Upon return to Homewood, the **14 day admission restrictions outlined above will restart** and you will be provided with a new wristband (if applicable)

This document is subject to change as we continue to monitor COVID-19 and we are taking the precautions outlined above extremely seriously. They are in place to limit the risk of exposure to the COVID-19 virus and protect our patients, your loved ones and our staff.

Thank you in advance for your cooperation.

I have read and understand the above and I agree to comply with all outlined guidelines in this document throughout my admission. I acknowledge that these guidelines may change during my treatment and that I will follow direction of Homewood Health Centre staff on these and any other matters related to the COVID-19 pandemic.

I also understand that any breach in the above guidelines may result in consequences, potentially including restarting my 14 day admission restrictions, limiting my privileges to my unit only, or discharge from my program and Homewood Health Centre.

_____ _____

Patient Signature Witness

_____

Date