

## PATIENT INFORMATION 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  
Fax: 519.767.3533 Email: admit@homewood.org  
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 INFORMATION

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?  Yes  No  Unknown

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**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Prosthetic leg    | <input type="checkbox"/> Glasses          | <input type="checkbox"/> No problem walking  |
| <input type="checkbox"/> Prosthetic arm    | <input type="checkbox"/> Contacts         | <input type="checkbox"/> Mobility aids (wheelchair, cane, walker, scooter, crutches) |
| <input type="checkbox"/> Lower Denture     | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Transfer assistance needed                                  |
| <input type="checkbox"/> Upper Denture     | <input type="checkbox"/> Hearing aids     | <input type="checkbox"/> Vision problems   |
| <input type="checkbox"/> Partial Bridge    | <input type="checkbox"/> CPAP machine     |  |
| <input type="checkbox"/> Other needs _____ |   |  |

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: \_\_\_\_\_

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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 Officer at [privacy@homewood.org](mailto:privacy@homewood.org) or 519.824.1010, extension 2443.*