

PRE-REGISTRATION FORM

Please send with Antenatal Record Part 1 & 2 to BCW Admitting (Fax:604-875-2971)
ASAP after 16 weeks GA (must be prior to 32 weeks)

Note: This form contains private and confidential information.
 If you are not the intended recipient, please do not read it. Inform BCW at 604-875-2152 ASAP, then destroy it.

Date Pre-Registration reviewed by BCW

FOR COMPLETION BY PATIENT: (Please complete this top section and return to your pregnancy care provider)

All Fields **MUST** be completed for this pre-registration to be processed

Baby's Due Date: _____ Family doctor: _____
 (Day / Month / Year)

BCW Pregnancy care provider who will deliver your baby: _____

Your Last Name: _____ First Name and Initial: _____
 (As it appears on your BC services card)

Last Name At Birth: _____ Your date of birth: _____ Pronouns: _____
 (Required by Vital Statistics) (Day / Month / Year)

Current Permanent Home Address: _____
 (Street Address) (City) (Postal Code)

Home/Cell Phone#: _____ Email: _____
 (must be completed if private pay)

Full Name of Spouse/Partner/Next of Kin: _____ Relationship: _____

Spouse/Partner/Next of Kin address: _____ Phone #: _____
 (If different from yours)

Indigenous Identity: Do you identify as Indigenous (First Nations, Metis, Inuit): Yes No If Yes, please specify: _____

Citizenship: Canadian Citizen Landed Immigrant Visitor Student/Work Visa Refugee

My Canadian Residency Is: Permanent Temporary, until _____

PHN / BC Service Card Number: _____ BCW Hospital Number: _____
 (For New Beginnings and Private Pay Pt. Only. BCW Pre-reg to complete)

Medical Insurance BC Medical Service Plan
 (MSP must be active – Uninsured Canadian Resident Complete Box 3)

Uninsured/Non-Resident (Self Pay)
 (complete box 3 documentations)

Do you consent to receiving a post-delivery survey by text or email?
Please circle: Yes or No

FOR COMPLETION BY BCW PHYSICIAN OR MIDWIFE OFFICE

FAX #: _____

Application for all **OUT OF PROVINCE** Patients (required document)

*Photocopy of out of province health insurance identification front and back

FOR COMPLETION BY BCW PHYSICIAN OR MIDWIFE OFFICE

FAX #: _____

Application for all **UNINSURED Resident /SELF PAY** Patients (**all * documents required with Pre-Registration form**)

*Copy of Passport

Please Select Mode of Delivery*

*Copy of Visa/ETA

Intended SVD

*Mailing Address in Home Country

Planned Cesarean

*Proof of current BC address – Home/Rental Insurance Only

For BCW Administration Only: Accepted Declined