BC WOMEN'S HOSPITAL+ HEALTH CENTRE
Provincial Health Services Authority

OBSTETRICAL OR Booking Form

Fax: 604- 602-8642

Patient Name:

DOB:

PHN:

Phone:

Address:

Section 1

Date Decision to Operate

Referral to OB Date

MRP

Surgeon

Classification

MRP

Office Phone #

Office Fax #

Pediatrics / NICU?

OB available dates

OB NOT available dates

Target GA

Indigenous patient navigator requested ☐ Interpreter needed ☐ Required language

Section 2 - Surgical Procedure Information

Primary Procedure

Secondary Procedure

Indication for C-section

Add'l Pt Info

Duration of Procedures(s)

Significant medical / surgical history

If yes, provide details:

Is advanced complex care plan required?

Alert: ☐ Weight Kg ☐ OSA ☐ MRSA/VRE ☐ Previous loss ☐ Surrogate

☐ Health care outside of Canada in the last 1 year

Section 3

Do you need an Anesthesia Consult?

if Yes reason

Anesthesia request *has been submitted*

Cell Saver ☐

Date of last u/s

EDD by U/S

Section 4 OR Booking Office use only

C-section Confirmed

Physician's office verified

OB OR Booking Package Check List

- ☐ OB booking form
- ☐ Signed Consent Procedure
- ☐ Consent for Blood Transfusion
- ☐ Pre-Anesthesia Questionnaire page 1 & 2
- ☐ Pre registration complete
- ☐ Antenatal part 1 & 2
- ☐ OB Consult
- ☐ Dating Ultrasound
- ☐ Survey consent

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BC Women's Hospital & Health Centre

CONSENT FORM

I, ☐ Patient or ☐ Legal Representative agree to the
(print name)
following investigation, treatment or procedure _____

_____

ordered by or performed by

_____

☐ Physician ☐ Registered Midwife ☐ Nurse Practitioner ☐ Other_ (print name)

The nature and anticipated effect of the proposed investigation, treatment or procedure has been explained to me. In particular, I have been informed of the following:

- Diagnosis/condition,
- Purpose and nature of the investigation/treatment/procedure,
- Risks and benefits of the investigation/treatment/procedure,
- Alternatives to the proposed investigation/treatment/procedure,
- Likely consequences of not undertaking the investigation/treatment/procedure.

I have had the opportunity to ask questions. I am satisfied with the explanations and understand them.

I understand and agree that for the purpose of medical education and improvement of service there may be residents/students attending my treatment/procedure, either watching or participating

I agree that the health care provider named above may have other surgeons, physicians and hospital staff assist him or her and may permit them to order and/or perform all or part of my treatments, surgical operation or procedure. I also agree that these other health care providers may have the same discretion in my treatment, operation, or procedure as the provider named above.

I also consent to such additional or alternative investigations, treatments or procedures as in the opinion of the health care provider named above finds are immediately necessary.

_____ _____
☐ Patient or ☐ Legal Representative (signature) Date (day/month/year)

_____ _____
Witness (signature) (print name)

I hereby confirm that the above-named investigation, treatment or procedure falls within my scope of practice. I also confirm that I have explained the nature and effect of the investigation, treatment, or procedure to the person who signed the above consent form.

_____
☐ Physician ☐ Registered Midwife ☐ Nurse Practitioner ☐ Other_

_____ _____
(print name) Date (day/month/year)

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CONSENT for

TRANSFUSION OF BLOOD and/or BLOOD PRODUCTS

1. Dr._____ has advised me that, in the course of my/my child's medical/surgical treatment, I/my child may need a transfusion of blood and/or blood products such as red blood cells, plasma, cryoprecipitate, factor concentrate, platelets, albumin or immunoglobulins.

2. I have been given information and have had the opportunity to ask questions about the benefits and risks of blood and/or blood products. I am satisfied that all my questions have been adequately answered. I understand what has been discussed.

3. Alternatives to transfusion have been discussed with me.

4. All blood donors are volunteers and are carefully screened by medical history and sensitive laboratory tests in order to minimize the risk of infectious disease transmission. Although the risk of infection or other adverse reaction from transfusion is very small, I understand that it is not possible to completely eliminate all risks of adverse reaction.

My signature below indicates that I consent to the transfusion of blood and/or blood products if it becomes necessary during the course of my treatment.

Special Instructions (if any – such as limitations to consent to include only specific blood products):

PATIENT / GUARDIAN

	Name of Patient	Signature of Patient	Date
And/or	Name of person legally qualified to give consent	Signature of person legally qualified To give consent	Date
	Relationship to patient		
	Name of Witness to above signatures	Signature of Witness to above signature s	Date

PHYSICIAN

I have discussed the benefits and risks of planned or potential transfusion therapy with the patient or parent/guardian.

Name of Physician	Signature of Physician	Date

OR

We certify, due to the potentially urgent need for transfusion, the inability to obtain informed consent and the lack of advance directives indicating refusal of blood/blood products, we are unable to obtain informed consent prior to transfusion therapy.

Name of Physician	Signature of Physician	Date
Name of Physician	Signature of Physician	Date

This form will remain valid only for the duration of the treatment course.

C-0506-06-61129

Revised: September 1, 2000.

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PRE-ANESTHETIC QUESTIONNAIRE

Patient's Name: _____ **Phone:** _____ **Email:** _____

Birth Date: _____ **Age:**_____ **Weight:** _____**KG** **Height:** _____**CM** **BMI:** _____**kg/m^2**

PLEASE COMPLETE BOTH SIDES OF THIS FORM

This form will be submitted to the hospital as part of your confidential medical record, and will be viewed only by hospital physicians and nurses directly involved in your care.

Have you ever had any of the following?	NO	YES	If 'YES' to any of the questions, please provide details below
Life threatening problems with anesthesia? (include general anesthesia, epidural, spinal, nerve block, or local anesthesia)	☐	☐	Anesthesia Consult required
Blood related family member with life threatening problem with anesthesia?	☐	☐	Anesthesia Consult required
Regular tobacco smoker?	☐	☐	☐ Current cigarettes/day____ years _____ ☐ Past—year quit _____
Regular alcohol usage?	☐	☐	Type: _____ amount/week ____
Regular recreational drug use?	☐	☐	Type: _____ amount/week ____
Regular severe heartburn or acid reflux	☐	☐	Order ranitidine
Current difficulty opening your mouth of bending your neck?	☐	☐	
Do you have obstructive sleep apnea?	☐	☐	☐ CPAP machine at home ☐ Sleep study? When/Where: _____
Shortness of breath with normal activity such as walking or climbing stairs?	☐	☐	If **'YES'**, please state how many: Blocks you can walk without stopping _____ Flights of stairs _____
Do you have ☐ Asthma ? ☐ Emphysema/COPD?	☐	☐	If **'YES'**, any attacks in the past 3 months?
Irregular heartbeats or palpitations?	☐	☐	☐ Atrial fibrillation ☐ Other:_____
High blood pressure?	☐	☐	
Heart related chest pain or angina?	☐	☐	Heart attack ? ☐ No ☐ Yes: When?_____
Heart surgery: ☐ bypass ☐ angioplasty ☐ pacemaker	☐	☐	Year:_____ Hospital: _____
Heart murmur or heart valve problems?	☐	☐	☐ Echocardiogram: when/where_____

Have you ever had any of the following?	NO	YES	If 'YES' to any of the questions, please provide details below
In the past 5 years, have you been seen by a **cardiologist** or had any of the following tests? Exercise stress test (treadmill test)? Nuclear medicine heart scan (MIBI)? Heart catheterization (angiogram)? Echocardiogram (heart ultrasound)?	☐	☐	Cardiologist name: _____ When/where: _____ When/where: _____ When/where: _____ When/where: _____
Stroke or transient ischemic attack (warning stroke)?	☐	☐	When: _____
Spinal cord injury OR surgery?	☐	☐	Paraplegic / Quadriplegic level: _____ Spine surgery / level:_____
Epilepsy / seizures?	☐	☐	Date of last seizure: _____
Diabetes ? ☐ Diet controlled ☐ Pills ☐ Insulin	☐	☐	
Liver problems, jaundice, hepatitis?	☐	☐	When: _____
Kidney problems?	☐	☐	☐ Dialysis ☐ Kidney transplant
Bleeding disorders or clotting problems?	☐	☐	☐ Hemophilia ☐ VonWillebrands Disease
Blood borne or other infectious diseases?	☐	☐	Details: _____
Refusal to receive blood products?	☐	☐	☐ Jehovah's Witness
Rheumatoid arthritis?	☐	☐	

Medications (including doses):

_____

_____

_____

_____

_____

If on **pain medication**, please indicate the maximum dose that you have taken on **ONE DAY** in the past month.

☐ This space is insufficient, a separate list of medications is attached

Medication Allergies (include reaction):

_____

_____

_____

_____

LATEX: ☐ **Contact** ☐ **Anaphylaxis**

IV contrast/iodine: ☐ **NO** ☐ **YES** _____

Do you speak conversational English? ☐ YES ☐ NO If 'NO', what language do you speak?

OBSTRUCTIVE SLEEP APNEA ASSESSMENT

☐ Do you snore loudly?

☐ Are you more tired during the day than you think you should be?

☐ Do you have high blood pressure?

☐ Are you older than 50 years old?

☐ Do you have a wide neck (more than 40cm)?

☐ Have you been told that you sometimes stop breathing when you snore?

☐ Is your BMI** greater than 35?

**Calculate BMI by dividing your weight in kg by your height in metres squared e.g. kg/M^2

STOPBANG SCORE (1 point for each 'YES' answer): _____

*** score ≥ 5 indicates likely moderate/severe sleep apnea**

My signature authorizes BC Women's Hospital to access my personal health information recorded elsewhere, for the purpose of providing medical care. This includes access to my **PharmaNet** medication profile and **Pathnet** laboratory information (Lifelabs).

_____ _____ _____

Date authorized **Patient Name (print)** **Patient Signature**

BC Women's Hospital Surgical Services

Communicating by Email

You will be receiving an email from BC Women's Hospital with instructions regarding your upcoming surgery.

This will come from the email address: BCWHSSOBPC@cw.bc.ca

BC Women's Hospital (BCWH) offers patients the opportunity to receive communications by email. At times BCWH uses email to share information with patients. We will only share information with you by email if you give us permission to do so. Your health information is private and personal, and we want to ensure you understand how your privacy may be impacted by agreeing to email communication.

This email is **not for the purpose of providing individual patient medical advice**; if you have a specific medical problem or concern, **please contact your surgeon**, or if an emergency, attend your nearest emergency department.

It is important you understand:

- Once an email message is sent we can't guarantee who will be able to see it
- We will double-check that the email address you give us is correct but sometimes we may make a mistake and the message could be sent to the wrong person
- We recommend that you delete emails you get from BCWH. Sometimes, even if you delete emails, backup copies may exist on your computer or in cyberspace
- Someone could hack your email account and look at your private information
- We have no way of knowing if you read the email we sent to you
- It is your responsibility to let us know if you email address changes
- It is your responsibility to let us know if you no longer want to receive your information by email

If you have questions about this email, please call the Obstetric OR pre-operating desk at 604-875-2000 ext. 1975 between 7:00am-2:00pm, Monday to Friday except statutory holidays.

Please provide your email address below if you consent to email communication:

_____ _____

Email Address Date

☐ I do not have an email address

☐ I do not wish to receive emails from BC Women's Hospital

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CONSENT FORM

STATEMENT BY PROFESSIONAL INTERPRETER:

I have translated the information on this form to the ☐ Patient ☐ Legal Representative, and I have interpreted their responses to the Physician, Registered Midwife or Nurse Practitioner.

☐ In the presence of the patient _____ _____
Professional Interpreter (signature) (print name)

☐ Over the phone (witnessed) _____ _____
Witness (signature) (print name & designation)

Date signed by Interpreter or Witness: _____ (day/month/year)

Telephone Consent: Health Care

I have discussed the procedure outlined on the other side of this form and the anticipated effects of such investigation, treatment, or operative procedure, including the significant risks and alternatives outlined with

_____ who is the patient's (state relationship)

_____, and he/she has given verbal consent for the procedure named above.

_____
Time Date

_____ _____
Signature of Health Care Provider obtaining consent (print name)

_____ _____
Witness (signature) (print name)

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Place patient's hospital identification sticker here

Improving Post Discharge Surveillance of Surgical Site Infection Following Cesarean Section at BC Women's Hospital

PATIENT CONTACT INFORMATION COLLECTION FORM

Information for Patients:

BC Women's Hospital is evaluating a new way of following up with patients who have recently undergone a cesarean section at the hospital. It is important for us to contact you once you have gone home from the hospital in order to find out if you have developed an infection at the site of your surgery wound. We would like to contact you so that we may invite you to complete a short online survey which will allow us to assess any complications you may have developed at the site of your surgery wound.

We would like to contact you to answer this online survey 30 days after your C-section. Your participation in this survey is completely voluntary.

If you provide your email address below we will send you a link to this survey by email. If you do not have an email address, please provide your phone number below and we will contact you by phone to ask you the survey questions.

Please note that the personal information that is collected through this form is collected in accordance with section 26(d) and (e) of the British Columbia Freedom of Information and Protection of Privacy Act, for the purpose of inviting you to participate in a survey that will assist us in evaluating our program of patient care. Your personal information will only be used by BC Women's Hospital for this purpose.

If you have any concerns, comments or questions about the survey and the collection and use of your personal information feel free to contact the Women's Health Research Institute at 604-875-2424 ext. 4909.

Contact information (required to send the online survey):

Date of Delivery (dd/mm/yyyy):____________________

First name: ___________________________ **Last name:**______________________________

Email address: __|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

If you do NOT have an email address, please provide your phone number.

Phone number: __|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|