Vancouver Coastal Health
Promoting wellness. Ensuring care.

Richmond Hospital
7000 Westminster Highway
Richmond, BC V6X 1A2

PRE-ADMISSION INFORMATION

(To be completed by the patient)

Patient's Legal Name _____
Surname Given Name(s) Previous Surname(s)

Personal Health Number (PHN) _____ OR ☐ Self Pay

Birthdate: Day _____ Month _____ Year _____

Gender: ☐ Male ☐ Female

A) Permanent Home Address Information

Address _____ City _____

Province _____ Postal Code _____ Country _____

Day or Cell phone _____ Home phone _____

B) Temporary / Local Address Information (if applicable):

Address _____ City _____

Province _____ Postal Code _____ Country _____

Day or Cell phone _____ Home phone _____

C) Email address (optional) _____

Admitting Physician / Midwife (provide both first and last name if known) _____

Family Physician (provide both first and last name if known) _____

Next of Kin / Emergency Contact _____
Surname Given Name(s)

Relationship _____

Day or Cell phone _____ Home phone _____

Preferred Accommodation (subject to availability): ☐ Private Room ☐ Semi-Private Room ☐ Standard Ward Room

Maternity Patient's Due Date: Day _____ Month _____ Year _____