

Delivery pre-admission questionnaire

To be completed between four to six weeks before due date.

Avec vous, pour la Vie

File number at the CHUS (hospital card No.) _____		Due date ____ / ____ / ____ Year Month Day	
Your surname _____	Your first name _____		Your birth date ____ / ____ / ____ Year Month Day
Social status <input type="checkbox"/> Single <input type="checkbox"/> Married (living with husband) <input type="checkbox"/> Common-law partner <input type="checkbox"/> Separated or divorced			
Surname of husband or partner _____		Name of husband or partner _____	
Mother's maiden name _____	Mother's first name _____	Father's surname _____	Father's first name _____
Quebec health insurance card number _____		Expiration date ____ / ____ Month Day	
Your address _____ Civic No. Street City Province Postal Code			
Phone No. _____ (Ind.rég) xxx - xxxx		Cell or pager No. _____ (Ind.rég) xxx - xxxx	
Place of birth _____		Do you wish to remain anonymous during your hospitalization? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, your room number won't be disclosed.	
Canadian nationality <input type="checkbox"/> Yes <input type="checkbox"/> No If not, which one is it: _____		If you are born outside Canada, how many years have you been here: _____ years	
Language of correspondence <input type="checkbox"/> French <input type="checkbox"/> English <input type="checkbox"/> Other _____			
In case of emergency, please advise _____ Surname First name	Phone No. _____ (Ind.rég) xxx - xxxx		Relationship _____

Other information (if applicable)

Employment status <input type="checkbox"/> Student <input type="checkbox"/> Occasional <input type="checkbox"/> Unemployed <input type="checkbox"/> Part-time <input type="checkbox"/> Full time		Your occupation _____	
Employer (company name) _____		Employer phone number _____ (Ind.rég) xxx - xxxx	
Employer address _____ Civic No. Street City Province Postal Code			
Your pharmacy's name _____		Address _____ Street City	
Your pharmacy's phone No. _____ (Ind.rég) xxx - xxxx			

Do you have a family doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, what are his surname and first name: _____
His clinic address _____ Civic No. Street City Province Postal Code	

Authorization for claim to your insurance company - Room fees

Most rooms in the maternity unit are private. However, if your insurance covers the cost of private or semi-private room, please complete this section so we can claim these fees to your insurance company. Thank you.

If you hold an insurance policy

Room type covered by your insurance <input type="checkbox"/> Private <input type="checkbox"/> Semi-Private	Name of insurance company _____
Certificate, participant or identity No. _____	Policy, contract or group No. _____

If your husband or partner hold an insurance policy that covers the room fees

Room type covered by your insurance <input type="checkbox"/> Private <input type="checkbox"/> Semi-Private	Name of insurance company _____
Name of your husband or partner's employer (company) _____	
Certificate, participant or identity No. _____	Policy, contract or group No. _____

Original signature of the user (or representative) _____ [Copy]	Relationship to the user if representative _____
Signature of the user (or representative) I, _____ have read and accepted that the CHUS bills my insurance company. "Enter your name" [Web form]	

Note: you can return the pre-admission questionnaire unsigned by email. In this case, it will be to sign on admission.

For use by the service d'accueil et d'admission

Initials - service d'accueil et d'admission _____	Date _____/_____/_____ Year Month Day
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Please return

- By email to serviceadmission.chus@ssss.gouv.qc.ca
- By mail to: CHUS - Hôpital Fleurimont
 Accueil et admission
 3001, 12^e Avenue Nord
 Sherbrooke, J1H 5N4
- If you already come for an appointment at the CHUS, you can return the questionnaire to the service d'accueil et d'admission located near the main entrance, room 2623.