North Bay Regional Health Centre

Bed Allocation Repat#: _____

Bed Request Form

HCN#:		DOB (dd/mm/yyyy):	J#:
Last Name:		First Name:	
Address:		Age:	Sex: ☐ M ☐ F
City:	Prov.:	Postal Code:	
Phone:	Phone (2):	Family Doctor:	
Allergies: ☐ Yes ☐ No		Tobacco Use in last 6 months: ☐ Yes ☐ No	

Person to Notify	Phone:
Last Name:	First Name:
Relationship: _____	

Request Source

Institution/Provider:		Referring Physician:
Contact Name:		Phone:
Contact Phone:	Ext:	Receiving Physician/MRP:

Reason for Admission

Repatriation: ☐ Yes ☐ No	Admission to any institution in the last year: ☐ Yes ☐ No, Where:

Primary Diagnosis:

Other Dx Conditions:

Comments:

Method of Patient Transport

Ambulance: ☐ Air ☐ Land ☐ Combined ☐ Police ☐ Family ☐ Other

Bed Type Needed:	**Special Considerations**	
	☐ Telemetry	
	☐ Bariatric	
	☐ Precautions:	
	☐ Isolation: Type:	

Receiving facility internal use only

Patient Flow notified: ☐ Yes ☐ No ☐ Message Left	Admission Date:
Receiving MD confirmation: ☐ Yes ☐ City Call MRP:	
Comments:	Date/Time Accepted and Receiving Floor:

Date: (dd/mm/yyyy)	Time (24 Hr):		Received by:

ALL INFORMATION TO BE COMPLETED AND FAXED TO _____

White copy – Health Record **Yellow copy – Patient Flow/Bed Allocation**