Gizhewaadiziwin Health Access Centre Client Registration

PROTECTED & CONFIDENTIAL

The information requested for this agreement will help us to provide you with the best services our circle of care has to offer. Your health information is kept secure and protected in accordance with legislative requirements, and will only be viewed by authorized persons for valid reasons. All employees have signed contracts that require them to keep your information confidential and safe.

Fields marked with * are mandatory

Personal Information:

***Which community do you live in? _____**

***Last Name:**		***First Name:**
***Middle Name:**		***DOB** (DD/MM/YYYY)**:**
Alias:	**Marital Status:** ❑ Single ❑ Married ❑ Common-Law ❑ Widowed ❑ Divorced ❑ Partner	
Service Eligibility Indicator:	❑ First Nation	❑ Registered Métis
❑ Other (please explain):		
***Band Name:**		***Indian Status / Métis Card #:**
***Health Card #:**		***Version Code:** ***Expiry:**

Contact Information:

***Mailing Address:**		***City:**	***Province:**
***Postal Code:**	***Home**✆**:**	**Work**✆**:**	**Cell**✆**:**
Email:	***Preferred Contact Method:** **(Check all that apply)**	❑ **Home** ❑ **Work** ❑ **Cell**	❑ **Email*** ❑ **Text*** *Consent Required
Emergency Contact:		**Relationship:**	
Home✆**:**	**Work**✆**:**	**Cell**✆**:**	

Do you have a Substitute Decision Maker (SDM)/Power of Attorney (POA) for Medical/Personal Care? ❑ Yes ❑ No

Do you have a Substitute Decision Maker (SDM)/Power of Attorney (POA) for Finances/Property? ❑ Yes ❑ No

SDM/POA Contact:		**Relationship:**
Home✆**:**	**Work**✆**:**	**Cell**✆**:**
Primary Contact Number: ❑ Home ❑ Work ❑ Cell		

If completing forms for a child or youth (under 18), please provide the following information:

Child is residing with: ❑ Both Parents ❑ Mother ❑ Father ❑ Caregiver ❑ Relative: _____

❑ Foster Parent(s) ❑ Group Home ❑ Other: _____

Agency Involvement: ❑ CAS/Band Rep ❑ Ontario Works ❑ Other: _____

If CAS is involved, please provide the following:
Agency Name: _____
Worker(s) assigned to the family (Include contact information)

Identify what type of agreement is in place?
❑ Customary Care ❑ Kinship Care ❑ Foster Care ❑ Temporary Care ❑ Crown Ward

Caregiver (Primary) Contact Information:		
Full Name	First:	Last:
Street:	City	Postal Code:
Primary Phone Number: ❑ Home ❑ Work ❑ Cell	Alternate Phone Number: ❑ Home ❑ Work ❑ Cell	
Relationship:		
Caregiver (Alternate) Contact Information:		
Full Name	First:	Last:
Street:	City:	Postal Code:
Primary Phone Number: ❑ Home ❑ Work ❑ Cell	Alternate Phone Number: ❑ Home ❑ Work ❑ Cell	
Relationship:		
Education:		
School:	Grade:	

Health Provider Information

1. Do you currently have a Family Physician/Nurse Practitioner? ☐ Yes ☐ No

*Primary Health Care Provider: _____ *Phone: _____

2. Do you currently see a Traditional Healer/Elder? ☐ Yes ☐ No

Traditional healer: _____ Phone: _____

3. Do you currently see a Mental Health Provider? ☐ Yes ☐ No

Mental Health/Addictions Counselor: _____ Phone: _____

4. Do you currently have a Family Dentist? ☐ Yes ☐ No

Family Dentist: _____ Phone: _____

5. Do you currently see an Optometrist? ☐ Yes ☐ No

Optometrist: _____ Phone: _____

Preferred health care: ☐ Traditional ☐ Contemporary/Medical ☐ Both

Personal Health Information:

We Ask Because We Care

Additional Information is required for Health Equity, Statistical Purposes and Funding Eligibility. We are collecting social information from clients to find out who we serve and what unique needs our client have. We will also use this information to understand client experiences and outcomes**.**

Do I have to answer these questions?

No. The questions are voluntary and you can choose 'prefer not to answer' to any or all questions. This will not affect your care at the Gizhewaadiziwin Health Access Centre.

How would you assess your health generally? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Do you smoke?	❑ Yes ❑ No	**Do you drink alcohol?**	❑ Yes ❑ No
If yes, how many cigarettes per day? _____ How old were you when you started? _____		If yes, how much/frequently? _____	
Do you exercise?	❑ Most of the time ❑ Sometimes ❑ No	**Do you eat a balanced diet?**	❑ Most of the time ❑ Sometimes ❑ No
Do you take prescribed medication?	❑ Yes ❑ No	**Do you feel stress/anxiety?**	❑ Most of the time ❑ Sometimes ❑ No

I have the following conditions:

❑ Chronic Illness
❑ Development Disabilities
❑ Drug or Alcohol Dependence
❑ Suboxone ❑ Methadone
❑ Learning Disability
❑ Mental Illness
❑ Physical Disability
❑ Sensory Disability (i.e. hearing or vision loss)
❑ HIV
❑ AIDS
❑ Hepatitis C
❑ Tuberculosis
❑ Other (please specify): _____
❑ None
❑ Do not know ❑ Prefer not to answer

My concerns/conditions include:
Check all that apply

❑ Arthritis
❑ Ear/Hearing Problems
❑ Kidney Disease
❑ Asthma or Lung Disease
❑ Eating Problems
❑ Learning Problems
❑ Behavioural Concerns
❑ Eye Problems
❑ Mental health issues
❑ Cancer
❑ Headaches
❑ Pregnancy
❑ Chronic Pain
❑ Heart Disease
❑ Seizures/Epilepsy
❑ Developmental Delays
❑ Hepatitis
❑ Stroke
❑ Diabetes
❑ High blood pressure
❑ Substance Addiction
❑ Other (please specify): _____

Socio-demographic Information

Language(s):	❑ English	❑ Ojibway	❑ Other (specify): _____
	❑ **I require a translator for my appointments**		
Gender	❑ Female ❑ Intersex ❑ Male	❑ Trans – Female to Male ❑ Trans – Male to Female ❑ Two-Spirit	❑ Other (specify) _____ ❑ Do not know ❑ Prefer Not to Answer
Sexual Orientation	❑ Bisexual ❑ Gay ❑ Heterosexual	❑ Lesbian ❑ Questioning ❑ Two-Spirit	❑ Other (Specify) _____ ❑ Do not know ❑ Prefer Not to Answer
Education:	❑ No formal ❑ Elementary	❑ Secondary ❑ Post-secondary	❑ Do not know ❑ Prefer Not to Answer

Disabilities	❑ Chronic Illness ❑ Developmental disability ❑ Drug or Alcohol Dependence ❑ Learning Disability	❑ Mental Illness ❑ Physical Disability ❑ Sensory Disability ❑ Other (Specify)	❑ Do not know ❑ Prefer Not to Answer

Please identify any accommodations that may be required for your appointment:
_____

Have you, or family members, ever attended residential school?
❑ Yes ❑ No ❑ Do Not Know ❑ Prefer not to answer
Were you, or another family member impacted by the 60's Scoop?
❑ Yes ❑ No ❑ Do Not Know ❑ Prefer not to answer

How were you raised? Check all that apply to you: ❑ Birth Family / Family of Origin ❑ Kinship Care / Extended Family ❑ Adopted ❑ Foster Care	❑ Group Home ❑ Other (Please specify) _____ ❑ Do not know ❑ Prefer not to answer

Occupation: _____

Spirituality/religion:	❑ Traditional	❑ Christian	❑ Both	❑Other (specify): _____
Household income:	❑ 0-$25,000	❑ 25,000-35,000	❑ 35,000-45,000	❑ 45,000-55,000 ❑ 55,000+ ❑ Do not know ❑ Prefer not to answer
Number of people in home:	_____			
Household composition:	❑ sole member ❑ single parent family ❑ multiple families		❑ extended family ❑ two-parent family ❑ other	
Living Arrangement:	❑ On Reserve	❑ Off Reserve	❑ Off Reserve Urban	
Type of housing:	❑ Apartment ❑ Group Home ❑ Home Owner ❑ Homeless ❑ Market rental ❑ Other – temporary		❑ Rooming House ❑ Shelter ❑ Subsidized Housing ❑ Do not know ❑ Prefer not to answer	

Please list any Medical Specialists, including any complementary health practitioners, and what you see them for:

Please list any known allergies (food, medications, environmental, insect) and your reaction:

Pharmacy:

Are you using any Traditional Medicines? ❑ Yes ❑ No

Are you currently on any medications? ❑ Yes ❑ No

If yes, please provide a LIST or CURRENT printout of all medications from your pharmacist or traditional healer. Please list any other medications you are taking, including items such as aspirin, laxatives, vitamins, calcium and other supplements, etc.

Your Current Pharmacy (Name and Address): _____

Pharmacy Phone Number: _____

Your Drug Plan:

❑ FNHIB (First Nation Health Insurance Benefit) ❑ ODB (Ontario Drug Benefits) ❑ Private

Immunizations:

Are your immunizations up to date? ❑ Yes ❑ No

May we obtain the immunization record? ❑ Yes ❑ No

Narcotics Statement. Please read and initial.

In keeping with GHAC's Mission Statement and to assist the clients to improve their quality of health and to live in a more balanced state of well-being, narcotics will be prescribed by the physicians and nurse practitioners (as per regulatory authorization) under certain circumstances (i.e. cancer, palliative care, acute injury).

The physicians and nurse practitioners will work closely with the client and/or their families using an integrated care approach to determine what alternate treatment options are available or should be explored to assist the client (i.e., internal referrals to Traditional Healing, Massage Therapy, Physiotherapy, and Mental Health).

When appropriate, external referrals may be made on behalf of the client to address their pain needs. These referrals will be discussed and agreed upon with the client as appropriate and deemed by the medical professional's clinical judgement.

Initial Here: _____

I am requesting the following Integrated Wholistic Care Service(s):

Traditional Healing. If yes, please indicate your reason for seeking Traditional Healing Services Care?

_____

_____

❑ Prefer not to answer

Mental Health Services for Adults or Children. If yes, please indicate your reason for seeking Mental Health Services.

_____

_____

❑ Prefer not to answer

Clinical Services (including Doctor, Nurse Practitioner, Dietitian, Diabetes Team, FASD, PCAP, Health Education). If yes, please indicate your reason for seeking Clinical Services.

_____

_____

❑ Prefer not to answer

I am interested in learning more about the following services:

❑ Physician Care
❑ Nurse Practitioner Care
❑ Diabetes Care
❑ Traditional Healing
❑ Counseling / Emotional Wellness
❑ Smoking Cessation
❑ Healthy Eating
❑ Active Living
❑ Diabetes Prevention
❑ Prenatal Education
❑ Respiratory Health Education
❑ Parenting/Family Support
❑ Translation Services
❑ Fort Frances Tribal Area Health Services

Our teams work together within a Circle of Care to provide the best service possible for our clients. If you access services from more than one area of the organization, your health information may be shared to ensure you receive the most appropriate care. **All information is kept confidential, and is used only for health-care related purposes.**

Additional information:

Client signs off on Client Consent which is attached to and forms part of this registration

For internal use only.
To be completed by GHAC staff (please complete, date and initial)

Have referrals been sent for:

❑ Clinical Services ❑ Yes ❑ No ❑ N/A with: _____ Date: _____ Initials: _____
❑ Mental Health ❑ Yes ❑ No ❑ N/A with: _____ Date: _____ Initials: _____
❑ Traditional Healing ❑ Yes ❑ No ❑ N/A with: _____ Date: _____ Initials: _____

Intake/First Appointments Booked ❑ Yes ❑ No Date: _____ Initials: _____
Chart is created in NOD? ❑ Yes ❑ No Date: _____ Initials: _____
Clinical Service Intake is ❑ Complete ❑ Incomplete? Date: _____ Initials: _____
Mental Health Intake is ❑ Complete ❑ Incomplete? Date: _____ Initials: _____
Traditional Healing Intake is ❑ Complete ❑ Incomplete? Date: _____ Initials: _____

Data entry is complete in EMR? ❑ Yes ❑ No Date:_____ Initials:_____

Has the Health Information Consent been entered in NOD as Signature on File with Date?
❑ Yes ❑ No Date:_____ Initials:_____

Gizhewaadiziwin Health Access Centre

1460 Idylwild Drive
P.O. Box 686
Fort Frances, ON P9A 3M9
Tel: (807) 274-3131
Fax: (807) 274-3855

PROTECTING YOUR PRIVACY

The Gizhewaadiziwin Health Access Centre (GHAC) is committed to protecting your personal information.

1. **We have responsibility for personal information.**
   GHAC is responsible for the information it holds about you and has policies about the confidentiality of this information.

2. **We are clear about why we collect information from you.**
   GHAC collects information about you so that we can provide you with health care and services as well as meet our reporting and legal obligations.

3. **We work in a team model where traditional healers, physicians, nurses, counselors, dietitians, community workers and a variety of skilled staff are part of providing high quality services to you and to the community.**
   Your information may be shared among staff of our health centre who are involved in your care in order to be able to help you most effectively.

4. **We ask for your consent (agreement) to collect, use and share your personal information.**
   Every client/patient (or his/her legally authorized representative) will sign an agreement about how we can use your personal information.

5. **We will limit the collection of personal information.**
   GHAC will only collect information that is necessary to provide good service to you and to our community and to meet our legal and funding obligations.

6. **We use personal information only for the purposes you have agreed to unless the use or sharing is permitted or required by law.**
   GHAC will not use your personal information for purposes other than care or services to you, evaluation, or managing and planning of services unless you agree or unless we are required by law.

7. **We take steps to safeguard your personal information.**
   GHAC will protect your information and ensure its privacy.

8. **You can ask about our privacy policies and practices.**
   A staff person can provide you with information about our policies and practices related to the management of personal information if you ask (and we will respond within a reasonable period of time).

9. **You have a right to know what personal information we hold about you and you can ask to see your records.**
   You have the right to request access to the information we have about you. You can request access to your information by simply writing us a note and signing it. The Centre will follow-up on your request.

10. **We respond to concerns and questions.**
    If you have questions or concerns about the way GHAC is carrying out these principles please contact our Privacy Officer at **(807)274-3131.**

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INFORMED CONSENT FOR SERVICES

I, _____,
(Print your name and relationship if you are a Parent / Guardian or Substitute Decision Maker)

For _____ Date of Birth: _____
(Self or Name of Person) (dd/mm/yyyy)

Consent to the following services:

_____
_____
_____,
as discussed with,
_____.
(Name of Service Provider)

I have been informed that it may be necessary for Gizhewaadiziwin Health Access Centre (GHAC) staff to consult with one another and to work collaboratively to enhance care.

It is my understanding that GHAC includes the following services to which I am entitled to participate: I have initialed the services that may share my personal information and specified any limitations.

- ❑ Diabetes Education and Management
- ❑ Fetal Alcohol Spectrum Disorder
- ❑ Maternal Child Health and Nutrition
- ❑ Mental Health Counseling for Adults, Children, Youth, Elders and Families
- ❑ Nutrition and Healthy Lifestyles
- ❑ Primary Health Care
- ❑ Traditional Healing
- ❑ Translation Services
- ❑ Pharmacy
- ❑ Public Health
- ❑ Fort Frances Tribal Area Health Services
- ❑ OATC

Specific Limitations:

_____
_____
_____

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Issues relating to services have been explained to me, and I have been provided with written information about limits to confidentiality. I understand that identified service providers who work with me, or on my behalf will consult both with me and with each other about my needs. I understand that the identified service providers will have information about me but only as necessary for us to plan, provide and evaluate my services.

All information is kept confidential, and is used only for health-care related purposes.

I understand that I can withdraw this consent at any time.

Signature of Individual, Parent(s), Guardian(s), Substitute Decision Maker	Date (dd/mm/yyyy)
Signature of Service Provider	Date (dd/mm/yyyy)

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HEALTH INFORMATION CONSENT
Consent for the collection and storage of Health Information

(by an Individual, Parent, Legal Guardian or Substitute Decision Maker)

Consent:
As part of our governance we are expected to adhere to the highest standards of practice. As such we require permission to collect, store, use and share information with others.

Limiting Collection:
Providing us with personal information is always the client's choice. Consent may be withdrawn at any time (subject to legal restrictions and with reasonable notice). The client may limit the information that we are able to share, or to limit those with whom we can share it. However, such limitations may restrict the services and/or programs we are able to provide. If the client chooses not to provide us with essential information, it is possible that we may not be able to provide the client with service or program opportunities. We will always do our best to resolve any concerns that the client might have so that we can provide him/her with programs and services in the best way possible.

There are also legal exceptions that preclude client consent as per Limits of Confidentiality.

Limited Use, Disclosure and Retention:
We will only use or share personal information for the purposes, for which it was provided, unless the law otherwise requires us. We will keep information for as long as the client remains involved with the organization. Once they no longer receive primary care services or attend programs at GHAC records will be kept for 10 years past the client's 18th birthday, based on the Regulated Health Professions Act. Records will be disposed of beyond that time frame using a secure manner.

Accuracy:
We will keep personal information as accurate, complete and up-to-date as possible.

Safeguards:
We secure our files, our computers and other locations where information might be kept or used. We ensure that all our staff, students and volunteers have signed a confidentiality statement and have received training on the organization's policies and procedures to protect client privacy. GHAC adheres to government regulations set out in the Personal Information Protection and Electronic Documents Act (PIPEDA) and the Personal Health Information Protection Act (PHIPA). If there is a security breach and personal information is stolen, lost or accessed by unauthorized persons, the client will be notified immediately.

As an organization we will review our policies and procedures for ensuring privacy every three years. In between policy reviews appointed staff are responsible for implementing a system to monitor organizational compliance to ensure privacy.

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Openness:
We will be happy to share information about our privacy policies and procedures. Our Privacy Officer, **Jandalyn Heil,** should be contacted at **807-274-3131** for further information.

I, _____,
(Print your name and relationship if you are a Parent / Guardian or Substitute Decision Maker)

For _____ Date of Birth: _____
(Self or Name of Person) (yyyy/mm/dd)

consent to GHAC collecting, using and disclosing health information as described above and acknowledge that I can limit, access, amend, and withdraw this consent at any time by providing written instructions to do so.

_____ _____
Signature of Individual, Parent(s), Guardian(s), Substitute Decision Maker Date (yyyy/mm/dd)

_____ _____
Signature of Service Provider Date (yyyy/mm/dd)