Grand River Community Health Centre

363 Colborne Street Brantford ON. N3S 3N2

intake@grchc.ca

The information requested on this form will help us assign you a primary care provider (doctor or nurse practitioner).
We are collecting information from clients to find out what unique needs our clients have.
We may use this information for statistical purposes but you will not be identified at an individual level.

Primary Care Intake Form

General Information

Last Name:_____First Name:_____Preferred Name:_____

Pronouns (check **one**): ☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Their
☐ Other (please specify): _____

Biological Sex (check one): ☐ Male ☐ Female ☐ Intersex

Health Card #:_____Version Code (letters):_____Expiry: _____

Birth Date:_____/_____/ _____
(dd) (mm) (yyyy)

Address:_____
(Apt. #) (No. And Street) (City) (Postal Code)

Preferred Contact #: _____ Message allowed? Yes ☐ or No ☐
Back- up Contact #: _____ Message allowed? Yes ☐ or No ☐

Your email Address: _____
I agree that GRCHC may contact me using my email for the purpose of providing information regarding specialist appointments, diagnostic testing or information related to our upcoming programs, clinics, and events at GRCHC. I understand any emails regarding personal health information are sent over a secure system using OceanMD. I understand at this time, messages from GRCHC will not allow for any email response from me. GRCHC will not share your email address with any third party. **Please initial here**: _____

Emergency Contact Name:_____Phone/Cell #:_____Relationship: _____

Please list all children under the age of 16 who need care at GRCHC (complete package for each child)

Name	Date of Birth	Relationship

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Health Care Providers

Do you currently have a primary care doctor or nurse practitioner elsewhere? Yes ☐ No ☐

If YES, provide full name of doctor/nurse practitioner and the city where located: _____

If NO, by signing here you confirm you do not currently have a doctor/nurse practitioner: _____

When was the last time that you saw a primary care doctor/nurse practitioner? _____

Do you see any specialists for your care? Yes ☐ No ☐ If yes, please complete the following table:

Specialist Name	Reason for Visit	Date of Last Visit

Medical History

Have you been diagnosed with any medical conditions? Yes ☐ No ☐ If yes, please complete the following table:

Medical Condition (e.g. diabetes, high blood pressure, etc.)	Year Diagnosed

Are you or could you be pregnant? Yes ☐ No ☐

Have you ever seen a therapist or counsellor for mental health support? Yes ☐ Year: _____ No ☐

Hospital Visits

Have you been to the hospital (Emergency Department or admitted) in the past year? Yes ☐ No ☐

If yes, please indicate the reason for visit/admission: _____

Have you had any surgeries? Yes ☐ No ☐ If yes, please complete the following table:

Surgery	Year

Current Medication

Are you currently taking any medications? Yes ☐ No ☐ If yes, please complete the following table:

Prescribed Medications (name and dose)	Prescribed by
Over the Counter Medications	

Name of Pharmacy: _____ **Location**: _____

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Please read the following and initial each statement to provide your consent:

☐ The above information is accurate to the best of my knowledge. I understand that if I knowingly give false or misleading information, GRCHC may not be able to offer services.

☐ I understand that my information will be stored in a secure electronic medical record.

☐ I understand that my information will be kept confidential in accordance with the Personal Health Information Protection Act (PHIPA).

☐ Grand River CHC staff work as a team to provide services and I understand that I may work with more than one staff member.

☐ I understand that some of the information I have provided is required by the Ministry of Health and Long Term Care. It will help Grand River CHC and our funders plan for and deliver programs. Grand River CHC will release this information without names or other personal details.

☐ Grand River CHC may need to share personal and medical information with GRCHC staff about you to provide the best care/services possible.

Thank you for completing this package. We will be in touch with you shortly to finalize your file. If you have any questions about this Client Intake Package, please call (519) 754-0777 ext. 255.

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Client Rights and Responsibilities

Client Rights:

Staff, students and volunteers will work as a team to ensure group participant needs are met. This will be accomplished by respecting the "client rights."

A client of GRCHC has the right to:

- Feel welcome while at Grand River Community Health Centre
- Be treated in a considerate and respectful manner, where uniqueness is valued, and consideration is given to the client as a whole person
- Receive services and attend programs in a clean environment
- Have personal health information kept private and confidential
- Be informed about your care, have opportunities to ask questions and share your concerns to support you to make decisions about your care
- Accept or decline treatment and learn how doing so might impact your health
- Bring a support person to any appointment or request accommodation if needed
- Provide feedback

Client Responsibilities:

Staff, students and volunteers commit to working in partnership with group participants. Clients are in turn expected to uphold certain responsibilities

A client of GRCHC is responsible to:

- Act in a way that allows other clients and our staff to feel safe
- Treat others with respect including respecting the gender, sexual orientation, ethnic, cultural and religious values of all GRCHC clients, visitors, volunteers, students and staff
- Attend and be on time for appointments and programs
- Share with us information necessary for your care including any changes in your contact information
- Be accountable for your actions
- Keep appointments, or cancel appointments in a timely fashion
- Inform reception or your service provider if you have cough, fever and/or flu-like symptoms
- Any behavior that is found to be abusive, threatening, and/or destructive may result in having the person leave and/or may be grounds for service restriction

I have read and understood my rights and responsibilities as a client of the Grand River Community Health Centre.

Client Name:_____ Client Signature:_____ Date: _____