

Please Read This First

Thank you for considering the Grand River CHC for your health & wellness needs. The following will answer many of the common questions we receive about intake and our Centre.

GRAND RIVER COMMUNITY HEALTH CENTRE

We believe everyone matters. We provide primary health care (medical) services, nutrition services, social work and counselling, health & wellness programs, specialized programs such as Caring for My COPD and Memory Clinics, outreach programs such as Migrant Farm Worker programs, and we participate in a variety of community partnerships and initiatives.

CLIENT INTAKE PROCESS

To ensure we are the right fit for you, please carefully read this sheet, including the rights & responsibilities on the reverse, before submitting an intake application.

Step 1: Fill in an intake application form

Intake application forms are available on our website and at the front desk. If you need help filling in the form, please contact our client services coordinator at 519.754.0777 ext 269. It is important that you complete the form in as much detail as possible.

Step 2: Submit the application form

Your completed form can be dropped off with our front reception staff. Please do not send your completed form to us by email, to protect the privacy of your information.

Step 3: Application Process

As a first step in processing your application, our office will contact you to update your package as needed. Please be patient as this can take some time, depending on the number of applications. If the centre is deemed the right fit, you will be notified of your first appointment with your primary care provider. If you already have a health provider at a different centre, please do not leave your provider until it is determined that we are able to meet your needs. Making primary care services available to community members without existing primary care providers is a priority of our CHC.

Step 4: Your first appointment

Your first meeting with your provider at the Centre will be a “meet and greet” getting to know you meeting. No prescriptions will be provided during this first visit. Your medications will be reviewed and it is possible they may be changed. You will need to bring all medications you currently take with you to this appointment.

PAIN MANAGEMENT AND NARCOTICS

We do not have the capacity at this time to provide primary health care for individuals requiring narcotics as part of their regular care.

CLIENT RIGHTS & RESPONSIBILITIES

Please read the Client Rights & Responsibilities on the reverse. If you have any questions or concerns about these rights & responsibilities, please contact our client services coordinator.

Client Rights and Responsibilities

Client Rights

Staff, students and volunteers work as a team to ensure client needs are met. This is accomplished by respecting the “client rights.”

A client of GRCHC has the right to:

- Be treated in a considerate and respectful manner, where uniqueness is valued, and consideration is given to the client as a whole person.
- A clean, comfortable, scent free, safe and secure environment
- Receive quality services that comply with health care standards
- Make a formal compliment or complaint about care
- Bring a support person to any appointment
- Have personal health information treated in confidence and used in a way that respects individuals wishes
- Be advised, in non-clinical terms, of information necessary to give informed consent or refusal to the proposed plan of care, including known risks, alternatives, and cost implications, if any
- Consent to treatment or be informed of the consequences of refusal

Client Responsibilities

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

A client of GRCHC is responsible to:

- Keep appointments, or to cancel appointments in a timely fashion (24 hrs. notice)
- Arrive at appointments on time
- Act in a considerate , respectful and non-threatening, non aggressive manner towards staff, other clients, and individuals at the Centre
- Inform the Centre of changes in contact information, as an example your address and phone number and contact information of another person if we are unable to reach you.
- Refrain from being under the influence of alcohol or illegal substances (drugs) when visiting the Centre
- Disclose information necessary for care, including the use of outside health care providers
- Follow mutually agreed upon treatment plans or let the Centre know if no longer following the treatment plan
- Attend to personal hygiene appropriate for assessments and treatments prior to coming to the Centre, including providing information about possible bed bugs.
- Use prescriptions and or medical devices as prescribed



363 Colborne Street Brantford ON. N3S 3N2
Telephone: (519) 754-0777

The information requested on this form will help us assign you a primary care provider (doctor or nurse practitioner).
We are collecting social information from clients to find out what unique needs our clients have. We will also use this information to understand client experiences and outcomes.

Primary Care Intake Form

General Information

Last Name: _____ First Name: _____ Preferred Name: _____

Health Card #: _____ Version Code (letters): _____ Expiry: _____

Birth Date: _____ / _____ / _____
(Month) (Day) (Year)

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

Preferred Contact #: _____ Message allowed? Yes or No

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

Best time to call to reach you in person: _____

Your email Address: _____

If no personal phone number how else can we contact you? (E.g. community worker, friend, family)

Name: _____ Phone #: _____ Message allowed? Yes or No

Emergency Contact Name: _____ Phone/Cell #: _____

Relationship: _____

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

Gender (check **one**): Male Female Intersex Trans (female to male) Trans (male to female)
 Two Spirit Gender fluid Other (please specify) _____
 Do not know Prefer not to answer

Sexual Orientation (check **one**): Heterosexual Gay Lesbian Bisexual Queer Two Spirit
(Only answer if intake form is for yourself) Do not know Prefer not to answer

Please list all children under the age of 16 who need care at GRCHC

Name	Date of Birth	Relationship

Please complete separate Intake Package for each child requiring care/services at GRCHC

Social/Cultural Information

1. What language do you feel most comfortable speaking in with your health care provider? (check **one** only):

- English French Arabic Bengali Chinese (Cantonese) Chinese (Mandarin)
 Czech Dari Farsi Greek Hindi Hungarian
 Italian Korean Nepali Polish Portuguese Punjabi
 Russian Serbian Slovak Somali Spanish Tamil
 Turkish Ukrainian Urdu Vietnamese ASL Mohawk
 Cayuga Ojibway Cree Other Indigenous (please specify) _____
 Other (please specify) _____ Do not know Prefer not to answer

2. What is your current Household composition? (check **one** only):

- Couple with children Couple without children Single parent (mother) Single parent (father)
 Sole Member Extended family Siblings Unrelated housemate
 Grandparents with grandchildren

3. Place of residence (check **one** only):

- House Apartment/Condo Shelter Homeless

Ethnic/Cultural Information

1. Were you born in Canada? Yes No

a. If NO, when did you arrive in Canada? _____

b. If NO, what country were you born? _____

- Canadian citizen Permanent resident Refugee Other: _____

2. Which of the following best describes your racial or ethnic group?

- Asian-East (eg. Chinese, Japanese, Korean)
- Asian-South (eg. Indian, Pakistani, Bangladeshi)
- Asian South-East (eg. Malaysian, Filipino, Vietnamese)
- Black-African (eg. Ghanaian, Kenyan, Somali)
- Black-Caribbean (eg. Barbadian, Jamaican)
- Black-North American (eg. Canadian, American)
- First Nations
- Indian-Caribbean (eg. Guyanese with origins in India)
- Indigenous/Aboriginal
- Inuit
- Latin American (eg. Argentinian, Chilean, Salvadoran)
- Métis
- Middle Eastern (eg. Egyptian, Iranian, Lebanese)
- White-European (eg. English, Italian)
- White-North American (eg. Canadian, American)
- Mixed Heritage (eg. Black-African & White-North American) please specify: _____
- Do not know
- Prefer not to answer

Education and Income

1. Highest level of education completed? (check **one** only):

- Primary (grades 1-8) Secondary (grades 9-13) Post-secondary (College-University)
- No formal schooling do not know Prefer not to answer
- Other (please specify): _____

2. What is your total household income before taxes last year? (check **one** only)

- \$0 - \$14,999 (\$1,249/month or less; \$7.69/hour or less)
- \$15,000 - \$19,999 (\$1,249 – 1,667/month; \$7.69 - \$10.26/hr)
- \$20,000 - \$24,999 (\$1,667 - \$2,083/month; \$10.26 - \$12.82/hr)
- \$25,000 - \$29,999 (\$2,083 - \$2,500/month; \$12.85 - \$15.38/hr)
- \$30,000 - \$34,999 (\$2,500 - \$2,916/month; \$15.38 - \$17.95/hr)
- \$35,000 - \$39,999 (\$2,916 - \$3,333/month; \$17.95 - \$20.51/hr)
- \$40,000 - \$59,999 (\$3,333 - \$4,999/month; \$20.51 - \$30.77/hr)
- Over \$60,000 (over \$5,000/month; \$30.77/hr and up)
- Do not know
- Prefer not to answer

3. How many people does this income support in your household?

Including: dependent parents, children, support payments etc.: _____

- Do not know Prefer not to answer

Health Care Providers

Do you have a current primary care doctor or nurse practitioner? Yes or No

If yes, name of 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 or No

If yes, please complete following table:

Specialist Name	Reason for Visit	Date of Last Visit

I declare that I do not have a primary health care provider (doctor or nurse practitioner) in Brantford/Brant County.

Please sign here _____

Medical History

Have you been diagnosed with any medical conditions? Yes or No

If yes, please complete following table:

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

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

Have you ever seen a therapist or counsellor? Yes Year: _____ No

Hospital Visits

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

If yes, reason for visit/admission: _____

Have you had any surgeries? Yes or No

If yes, please complete following table:

Surgery	Year

Current Medication

Are you currently taking any medications? Yes or No

If yes, please complete following table:

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

Name of Pharmacy: _____

Thank you for completing this package. Please read the following and initial each statement:

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 care / services and I understand that I may work more than one health care professional.

Grand River CHC may contact me for appointment reminders or other information that may be of interest to me.

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, and referred specialists, about you to provide the best care/services possible.

Client/Parent/Guardian Signature _____

Date: _____

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- Arrive at appointments on time
- Behave in a respectful and non-aggressive manner towards staff and other clients
- Inform the health centre of changes in contact information (i.e. address and phone number)
- Refrain from being under the influence of alcohol or illegal substances (drugs) when visiting the health centre
- Disclose information necessary for care, including the use of outside healthcare providers
- Follow mutually agreed upon treatment plans or let the health centre know if no longer following the treatment plan and why
- Talk to staff about any hygiene concerns prior to coming to the health centre
- Use prescriptions and or medical devices as prescribed

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

Client/Parent/Guardian Name: _____ Client signature: _____

Date: _____