

## Information for applicant - 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 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, 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. 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: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(dd) (mm) (yy)

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: \_\_\_\_\_

**\*\*at GRCHC we are starting to use email as a way to share information with our clients\*\***

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  Transmale  Transfemale  
 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 for mental health support? 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, and 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.
- I agree to provide my email address and 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 that GRCHC cannot guarantee the security of email messages. I understand that email messages may pose a risk to my privacy. I understand at this time, messages from GRCHC will not allow for any email response from 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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**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: \_\_\_\_\_