De dwa da dehs nye>s Aboriginal Health Centre

New Patient Intake Form

Please complete all appropriate sections

Date (DD/Month/YYYY): _____

New Patient Intake Form (Please complete ONE form PER PERSON)	
DAHAC site location:	☐ Hamilton ☐ Brantford ☐ Niagara (St. Catharines)
I am completing this form for:	☐ Myself ☐ My Child ☐ Other _____
Please complete this form with the patient's information	

1. Patient Demographic Information

Full Name (First / Middle / Last) (as appears on Health Card):

Preferred First Name (if different):

Date of Birth (DD/Month/YYYY):

Patient identifies as:
☐ First Nation (Status) ☐ First Nation (Non-Status) ☐ Métis ☐ Inuit
☐ Other (please identify): _____

FN Status Number (Registration Number) or Métis Membership # or Inuit ID Number is:

_____

Band Name (if applicable): _____ Band Number (if applicable): _____

Live on Reserve: ☐ Yes ☐ No

If yes, what community: _____

If no, is the living area: ☐ Urban ☐ Rural

Does the patient identify as a member of the 2SLGBTQ+ community? ☐ Yes ☐ No ☐ Other: _____

If the patient is a person with a Disability, **please identify any accommodations** required for appointments.

Health Card NO:	Sex:
Version Code:	Expiry Date:

2. Address and Contact Information

Street:	City:	Postal Code:
Primary Phone #: ☐Mobile ☐ Work ☐Home	Alternate Phone # ☐Mobile ☐ Work ☐Home	

Email Address:

Preferred means of communication:
☐Mobile ☐ Work ☐Home ☐Text **(*Consent required)** ☐ Email**(*Consent required)**
Consent form attached to intake form, please sign

Mailing Address (Alternate Address) ☐ same as above

Street:	City:	Postal Code:

Emergency Contact Person:	
Name:	Relationship to patient:
Primary Phone #: ☐Mobile ☐ Work ☐Home	
Do you have a Substitute Decision Maker (SDM)/Power of Attorney (POA) for Medical/Personal Care?: ☐ Yes ☐ No	
SDM/POA Name:	Relationship to patient:
Primary Phone #: ☐Mobile ☐ Work ☐Home	

4. If completing forms for child or youth (under 18) Please provide the following information, otherwise continue to section 5.		
Legal Guardian (s):		
Relationship to child / youth:		
Child is Residing with: ☐ Both Parents ☐ Mother ☐ Father ☐ Caregiver ☐ Relative: _____ ☐ Foster Parent(s) ☐ Group Home ☐ Other: _____		
4a. Caregiver (Primary) Contact Information		
Full Name (First/Last):		
Street:	City:	Postal Code:
Primary Phone #: ☐Mobile ☐ Work ☐Home	Alternate Phone # ☐Mobile ☐ Work ☐Home	
Relationship to patient:		
4b. Caregiver (Additional) Contact Information		
Full Name (First / Last):		
Street:	City:	Postal Code:
Primary Phone #: ☐Mobile ☐ Work ☐Home	Alternate Phone # ☐Mobile ☐ Work ☐Home	
Relationship to patient:		

5. Current Primary Care Services	
Does the patient presently have a Family Physician/Nurse Practitioner?	☐ Yes ☐ No
Provider's Name:	
Provider's Address/Phone #:	
Does the patient presently see a Traditional Healer/Elder?	☐ Yes ☐ No
Healer/Elder's Name:	
Does the patient presently see a Mental Health Provider?	☐ Yes ☐ No
Provider's Name/Organization:	

6. Current Health Concerns/Conditions

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): _____

_____

_____

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

_____

_____

_____

List any known allergies: (food, medicines, environmental, insect) and reactions._

_____

_____

_____

7. Medications

Preferred Pharmacy (Name and address):			
Pharmacy Phone #:		Pharmacy Fax #	
Your Drug Plan:	☐FNHIB (First Nation Health Insurance Benefit) ☐ Ontario Drug Benefit (ODB) ☐ Private		
Are you using any Traditional Medicines?	☐ Yes ☐ No		

Present Medications:

☐ Not currently taking medication

☐ Please provide a LIST or CURRENT printout of all medications from your pharmacist. (List any other medications you are taking. Including items such as aspirin, laxatives, vitamins, calcium and other supplements, etc.

Are you taking any of the following medication:

☐ Tylenol 1	☐ Tylenol 2	☐ Tylenol 3	☐ Percocet	☐ Oxycontin
☐ Hydromorphine	☐ Oxyneo	☐ Tramacet	☐ Tramadol	☐ Endocet
☐ Methadone	☐ Codeine	☐ Oxycocet		
☐ Other pain medication (please specify)				

_____

_____

Narcotics Statement. Please read and initial.

In keeping with DAHAC'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: _____

Is there any other relevant information you would like us to know?

_____

_____

_____

PLEASE NOTE: You will be contacted by our clinic when an intake appointment is available. Please call us if there is a change to your contact information. If we are unable to reach you after three attempts, you will be removed from the waitlist.

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

Intake is ☐Complete ☐Incomplete? Date: _____ Initials: _____
Intake is ☐Complete ☐Incomplete? Date: _____ Initials: _____
Intake is ☐Complete ☐Incomplete? Date: _____ Initials: _____
Chart created in the EMR? ☐Yes ☐No Date: _____ Initials: _____
Consent obtained/added to the EMR? ☐Yes ☐No Date: _____ Initials: _____
Contact information updated: Date: _____ Initials: _____
Contact information updated: Date: _____ Initials: _____
Contact information updated: Date: _____ Initials: _____
Notes

_____

INFORMED CONSENT FOR TEXT MESSAGING AND/OR ELECTRONIC MAIL (Email)

Please check which form(s) of communication apply: ☐ **Email** ☐ **Text Messaging**

Client Name: _____

NOTE TO CLIENT: We require your informed consent. In order to communicate with you by text messaging and/or email, we need to make sure you are aware of the privacy risks and other issues that arise when we communicate this way and to document your agreement, knowing the risks involved.

- I understand that text messaging and/or email is not appropriate for emergency or urgent situations. Confidential matters between me and De dwa da dehs nye>s will not be communicated by text messaging and/or email
- I understand that I am not able to access my worker before or after work hours (regular work hours are: Monday – Friday 8:30a.m. – 4:30 p.m. and that I should contact emergency services if I require immediate assistance.
- I understand that text messaging and/or email with De dwa da dehs nye>s is limited to appointment scheduling, rescheduling, and appointment reminders.
- I understand that text messaging and/or email correspondence may be included in my file.
- I understand that De dwa da dehs nye>s will not forward my texts and/or email, without my consent to any third party except as authorized by law.
- I understand that De dwa da dehs nye>s is not liable for breaches of confidentiality caused by me or any third party (i.e. anyone else who accesses my cell phone or computer).
- I understand the risks and limitations associated with the communication of texts and/or email between DAHAC and me.

I declare that I have read, understood and agree to the contents of this Informed Consent for text messaging and/or electronic mail in its entirety. By signing this form, I understand the risks and limitations of text messaging and/or electronic mail

Name: (client) _____ Date of Birth (month/day/year) _____

Guardian or Substitute Decision-Maker (if applicable): _____

Relationship to Client: _____

Signature: _____ Date: _____

DAHC Staff Member: _____ Date: _____

Distribution: Copy to Client EMR
For more information please contact De dwa da dehs nye>s Privacy Officer at Privacy@dahac.ca