Glengarry Nurse Practitioner-Led Clinic
Cliniques dirigées par du personnel infirmier praticien de Glengarry

New Client Intake Form

Thank you for your interest to become a client at the Glengarry Nurse Practitioner-Led Clinic (GNPLC). The information collected in this form will be used for the purposes of determining your eligibility; primary care planning; Ministry of Health reporting and associated referrals. The GNPLC collects, uses and discloses personal information in compliance with the guidelines of the Personal Health Information Policy Act (PHIPA). Please answer the following questions to the best of your knowledge, so that we may learn more about you and assist in meeting your health care needs. Should you require help completing this form, please request assistance from a person close to you.

Demographic Information

Last Name: ______________________ First Name: _________________ Preferred name: __________

OHIP Card: __________________________________ Expiry: ___________

Gender: ❒ Male ❒ Female

Date of Birth (yr/mth/day) ________________

Address: _____________________________City:____________ Province:____ Postal code: _________

Home Phone: ___________________ Cell Phone: _____________ Work Phone: ___________________

May we leave a message on your phone (i.e to inform you that test results are in, clinic closure or programming) ❒ YES ❒ NO

Alerts:

In case of an **Emergency** contact: _______________________ Relationship to you: ________________

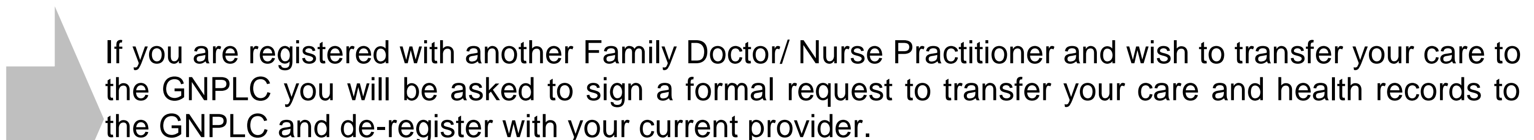
Home Phone: __________________ Cell Phone: __________________ Work Phone: ______________

ALLERGIES: (to medications, foods, latex, the environment, etc): _______________________________

NOTE: The GNPLC's target population is to serve those **without** access to a family doctor or other primary care provider.

Do you currently have a Family Doctor / Nurse Practitioner? ❒ YES ❒ NO

Name: ______________________________________ Address: ______________________________



If you are registered with another Family Doctor/ Nurse Practitioner and wish to transfer your care to the GNPLC you will be asked to sign a formal request to transfer your care and health records to the GNPLC and de-register with your current provider.

Are you prepared to transfer your care and health records to the GNPLC? ❒ YES ❒ NO

Other health care providers: **Who has been providing you healthcare? Please indicate all that apply**	
Provider	***Name & Date of last visit***
Physician or Nurse Practitioner	
Obstetrics or Gynecology (if applicable)	
Emergency Room	
Walk-In clinic	
Other: (specialists, consultants, psychiatrist, EAP, CCAC, massage therapy, acupuncture, chiropractor, physio, etc)	

When was you last physical exam: ______________________

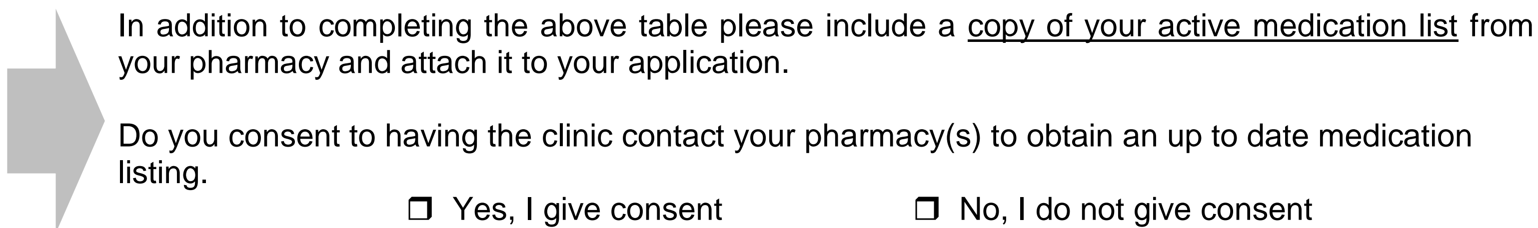
How would you rate your current health status? ❐ Poor ❐ Fair ❐ Good ❐ Very Good ❐ Excellent

Please list any known medical diagnoses (example: diabetes, heart disease, depression)	

Surgeries/ Hospitalizations/ Injuries- Please list date and details

Date	***Surgery (✓)***	***Hospital (✓)***	***Injury (✓)***	***Details***

Please list ALL current or recent Medications (prescriptions, over the counter, vitamins or homeopathic/herbal remedies)			
Drug Name	***Dose***	***How Often***	***Reason***
Sample/ Example: Aspirin	*325 mg*	*Daily, am*	*Lower back pain*



In addition to completing the above table please include a copy of your active medication list from your pharmacy and attach it to your application.

Do you consent to having the clinic contact your pharmacy(s) to obtain an up to date medication listing.

❒ Yes, I give consent ❒ No, I do not give consent

Which pharmacy(s) do you obtain your prescriptions from:

Pharmacy name: ______________________________ **Location:** ______________________

Pharmacy name: ______________________________ **Location:** ______________________

Immunization record

Please attach a copy of your or your child's immunization record.

Consent

I, ___________________________ understand and give consent to the Glengarry Nurse Practitioner-Led Clinic (GNPLC) to collect, use and disclose my personal information *(or I am completing this form on behalf of my child and am giving consent),* for the purposes of primary care planning and funder reporting, in accordance with the Personal Health Information Policy Act (PHIPA). Because staff at the GNPLC work with me as a team to provide me with the highest quality services, I understand that my personal information may be shared amongst those who are directly involved with my health care/ planning. Note: All GNPLC staff and students on placement, are required and committed to maintaining and protecting the confidentiality of your personal information.

Date: __________________

Please return this form to: **GNPLC** 137 Military Road,
P.O. Box 160
Lancaster, Ont. K0C 1N0 or by **fax:** 613.347.9896