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: __________

Pronoun: __________ Sex: _______ Gender: _______ Sexual Orientation:___________________

OHIP Card: ___________________________________ Expiry date: ___________

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:

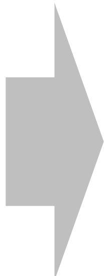
In case of an **Emergency** contact: ________________________ Relationship to you: _______________

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.



Are you currently registered with a Family Doctor or Nurse Practitioner and wish to transfer your care to the GNPLC?

❒ YES ❒ NO

If yes, Name: ____________________________ Address: ________________________________

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 your last physical exam: ________________________

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

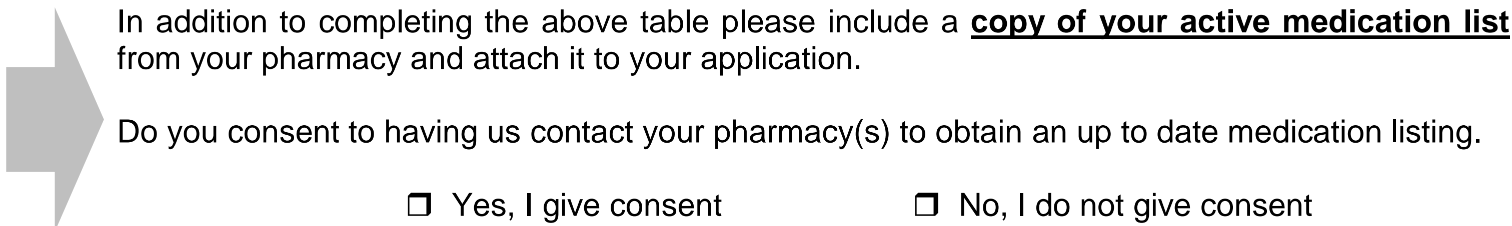
Please list any known medical diagnoses (example: diabetes, heart disease, depression)

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***
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 us 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, if completing this form for a child).

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 program/service partners are required and committed to maintaining and protecting the confidentiality of your personal information.

Date: __________________

Please return this form to: **Glengarry Nurse Practitioner-Led Clinic**
137 Military Road,
P.O. Box 160
Lancaster, Ont. K0C 1N0 or by **fax:** 613.347.9896

*** For OFFICE USE ***

This form was received by: ________________________________ Date: __________________

This form has been reviewed by: ____________________________ Date: __________________

Does this person meet the Nurse Practitioner scope of practice? ❐ Yes ❐ No

Is this person currently attached to another primary care provider. ❐ Yes ❐ No

Accepted for a *meet and greet* : ❐ Yes ❐ No

If no, reason and/or r**eferral/ recommendations**:

____

____

<u>Reception:</u>

Follow up decision ❐ accepted for *meet and greet* letter issued Date:_____________ By: _____

❐ declined letter issued Date:_____________ By: _____