Mamaway Wiidokdaadwin Indigenous
Interprofessional Primary Care Team

Intake Form

Please complete all appropriate sections Date (Day/Month/Year): _____

SECTION 1 Basic Information

Full Name (First/Middle/Last) from health card	Health Card Number	Version
Preferred Name (if different)	Date of Birth (Day/Month/Year)	

Marital Status

☐ Common-Law ☐ Divorced ☐ Married ☐ Single ☐ Separated ☐ Partner ☐ Widowed

I would identify myself as:

☐ First Nation (Status) ☐ First Nation (non-Status) ☐ Métis ☐ Inuit ☐ Other:

Registration Number:

Do you identify as a member of the LGBTQ2+ community?

☐ Yes ☐ No ☐ Other:

If you are a person with a Disability, please identify any accommodations required for your appointment.

SECTION 2 Address and Contact Information

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

Email Address:

Consent Complete:

☐ Yes ☐ No

Preferred means of communication:

☐ Mobile ☐ Work ☐ Home ☐ Text

Mailing address (alternate address) ☐ same as above or

Street	City	Postal Code

SECTION 2B **Emergency Contact Information**	
Name	Relationship
Primary Phone: ☐ Mobile ☐ Work ☐ Home	Alternate Phone: ☐ Mobile ☐ Work ☐ Home
Do you have a substitute decision maker (SDM) / Power of Attorney (POA) for medical care? ☐ Yes ☐ No	
SDM/POA Name	Relationship
Primary Phone: ☐ Mobile ☐ Work ☐ Home	Alternate Phone: ☐ Mobile ☐ Work ☐ Home

SECTION 2C **If completing forms for a child/youth (under 18) please provide the following:**	
Legal Guardian(s):	Relationship to child/youth:
Child is residing with: ☐ Both parents ☐ Mother ☐ Father ☐ Caregiver ☐ Foster parents ☐ Group home ☐ Relative (specify ☐ Other (specify)	
Agency Involvement: ☐ CAS / Band Rep. ☐ Other (specify)	

SECTION 3A **Caregiver Primary Contact Information**		
Full Name (First/Last)	Relationship:	
Street	City	Postal Code
Primary Phone: ☐ Mobile ☐ Work ☐ Home	Alternate Phone: ☐ Mobile ☐ Work ☐ Home	

SECTION 3B **Caregiver (Additional) Contact Information**		
Full Name (First/Last)	Relationship:	
Street	City	Postal Code
Primary Phone: ☐ Mobile ☐ Work ☐ Home	Alternate Phone: ☐ Mobile ☐ Work ☐ Home	

SECTION 3C Education

School	Grade	School Board

SECTION 4 Health Service Provider

Do you have a Family Physician/Nurse Practitioner: ☐ Yes ☐ No

Provider's Name:

Do you presently see a Traditional Healer/Elder: ☐ Yes ☐ No

Traditional Healer/Elder's Name:

Do you presently see a Mental Health Provider: ☐ Yes ☐ No

Mental Health Provider's Name:

SECTION 5 Request for Wholistic Care Services

I am requesting the following integrated Wholistic Care Service(s):

Traditional Healer: ☐ Yes ☐ No ☐ Prefer not to answer

If yes, please indicate your request of services for Traditional Healing Care in order that we may arrange the most appropriate healer for your needs.

Mental Health Services for Adults or Children: ☐ Yes ☐ No ☐ Prefer not to answer

If yes, please indicate how we may assist you with your needs.

Clinical and/or Complementary Services: ☐ Yes ☐ No ☐ Prefer not to answer

If yes, please indicate how we can assist you.

SECTION 6 General Well-Being

In describing my general well-being:

☐ Chronic Illness	☐ Sensory Disability (i.e. hearing or vision loss)
☐ Developmental Disabilities	☐ Other (please specify)
☐ Drug or Alcohol Dependence	
☐ Learning Disability	☐ None
☐ Mental Illness	☐ Do not know
☐ Physical Disability	☐ Prefer not to answer

My concerns or conditions include: (Please 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 use

☐ Other (please specify)

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

List known allergies: (food, medicines, environmental, insect) and your reaction.

SECTION 7 Medications

Are you using Traditional Medicines? ☐ Yes ☐ No

Present Medications:

☐ Not currently on medication

☐ Please bring medications or current printout of all medications from your pharmacist.

(List any other medications you are taking. Including such items like aspirin, laxatives, vitamins, calcium and other supplements, etc.) If more space is needed, please use the back of this page.

Pharmacy Name and Address	Pharmacy Phone Number

Your Drug Plan: ☐ NIHB ☐ Ontario Drug Benefits ☐ Private

SECTION 8 Your Story

~ We ask because we care. ~

Additional information is required for health equity, statistical purposes and funding eligibility. We are collecting social information from clients to find out who we serve and what unique needs our clients have. We will also use this information to understand client experiences and outcomes, as well as identifying gaps in service.

Do I have to answer these questions?

No. The questions are voluntary, and you can choose "prefer not to answer" to any or all the following questions. This will not affect your care at the Mamaway Wiidokdaadwin Primary Care Clinic.

We would like to get to know your family story. If comfortable please share with us here or at your meet and greet appointment if preferred:

SECTION 9 Demographic Information

Have you or any family members attended Residential School?

☐ Yes ☐ No ☐ Do not know ☐ Prefer not to answer

Were you or another family member impacted by the 60's Scoop?

☐ Yes ☐ No ☐ Do not know ☐ Prefer not to answer

My highest level of education is:

☐ Too young for primary completion	☐ No formal education
☐ Primary or equivalent (grades 1-8)	☐ Other
☐ Secondary or equivalent (grades 9-12)	☐ Do not know
☐ Post-Secondary or equivalent	☐ Prefer not to answer

What was your total family income before taxes last year?

☐ 0-$14,999	☐ $40,000 to $59,999
☐ $15,000 to $19,999	☐ $60,000 to $89,999
☐ $20,000 to $24,999	☐ $90,000 to $119,999
☐ $25,000 to $29,999	☐ $120,000 to $149,999
☐ $30,000 to $34,999	☐ $150,000 and over
☐ $35,000 to $39,999	☐ Do not know
	☐ Prefer not to answer

How many people does this income support?
_____ Persons
☐ Do not know
☐ Prefer not to answer

Who lives in your home?

☐ Couple with child (ren)	☐ Sole member (I live alone)
☐ Couple without child	☐ Siblings
☐ Single parent family	☐ Unrelated housemates
☐ Grandparent(s) with grandchild(ren)	☐ Other
☐ Extended family	☐ Do not know
	☐ Prefer not to answer

What type of housing or living arrangements do you have in place?

☐ Apartment	☐ Rooming House
☐ Group Home	☐ Shelter
☐ Home Owner	☐ Subsidized Housing
☐ Homeless	☐ Do not know
☐ Market Rental	☐ Prefer not to answer
☐ Other – temporary	

Personal Health Information and Privacy

I _____understand that the Mamaway Wiidokdaadwin Primary Care Team is responsible for keeping all the information collected about clients confidential. All personnel/staff at the primary care clinic are held accountable to policies regarding confidentiality, privacy, consent, the release of information (Personal Health Information Act, and the Privacy Act), and the set standards of their profession.

- Mamaway Wiidokdaadwin Primary Care Team will collect pertinent information necessary to provide effective services for clients, and to meet legal/funding requirements.
- To provide the best care possible, with your consent, information may be shared between appropriate team members.
- As an active participant in your care, your express consent will be sought when referrals are made to other professionals outside of our primary care team.
- A health care record is created for each client and electronically stored; Electronic Medical Record (EMR). This electronic medical record of your personal health information is password protected, with access restricted to appropriate staff (i.e. Nurse Practitioner, RN). Each member of our team that provides direct service will have their notes scanned onto your file by the medical office assistant and may not have access to your full medical record, dependent on their position.
- Personal information will not be used or disclosed for purposes other than those for which it was collected, except with your express consent or required by law.
- Personal information will only be kept until added to the EMR, then disposed of in a secure manner.
- All clients that access the clinic are asked to provide demographic information required by the Indigenous Primary Health Care Council (IPHCC). This information allows us to provide you with services and support, health equity, as well as, towards research reports and securing funding. Any information used for reporting or funding purposes will not be linked to your name or other identifying information.
- Clients will be informed of the reasons for the data collection, and signed consent obtained before any disclosure of their health information, or use.

Clients' Rights

Mamaway Wiidokdaadwin clients all share the following rights regarding their personal health information. They may:

- Access or obtain a copy of their information
- Request a correction of their information
- Have assistance in interpreting their record
- Withdraw or withhold consent

Assistance in understanding the record will be the responsibility of the primary care provider. If the provider is concerned that releasing the information could be harmful to the client; the team will be consulted prior to the release. Staff will respond to a request to view personal health information within 30 days.

Restrictions

I understand that no part of my medical record will be released to anyone outside of Mamaway Wiidokdaadwin Primary Care Clinic without my specific consent, except when the law requires. Examples of this include:

1. The law requires us to report to child welfare authorities when there is suspicion or disclosure of abuse or neglect of a child under the age of 16 years old.
2. If we have reason to believe a client will seriously harm himself/herself or another. A report would be made to authorities in order to ensure safety of all.
3. Records will be shared if we are required to do so by a court of law (subpoena).
4. If you disclose sexual abuse by a regulated health professional, identifying information cannot be disclosed without your written consent but the health professional must be reported to their college.

I have had the above information explained to me, I understand, and I consent to the above for the duration of my health care at Mamaway Wiidokdaadwin Primary Care Clinic.

Client's name (please print)	Witness/ Staff's name (please print)
Signature	Signature
Date	Date