

## Information for applicant - Please Read This First

The following will answer many of the common questions we receive about intake and our centre.

### **GRAND RIVER COMMUNITY HEALTH CENTRE – WHO WE ARE**

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 International Seasonal Worker programs, and we participate in a variety of community partnerships and initiatives.

### **APPLYING FOR A PRIMARY CARE PROVIDER**

Making primary care services available to community members **without** existing primary care providers is a priority at GRCHC. 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.

### **CLIENT INTAKE PROCESS**

Please complete each section of this application including the Consent section on pg. 3 requiring an initial in each box and the Client Rights and Responsibilities on pg. 4. If a section does not apply to you, write “N/A” for Not Applicable.

#### **Step 1: Fill in an intake application form**

Intake application forms are available on our website (<https://www.grandriverchc.ca/your-health/new-clients/>) and at the front desk. If you need help filling in the form, please contact our centre at 519.754.0777 ext. 308 or ext. 443. 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 submitted:

- in person to the GRCHC reception desk
- by email to [intake@grchc.ca](mailto:intake@grchc.ca) (**Note:** Non-secure email is not a secure form of communication. Submitting personal information via email is at your own discretion.)

#### **Step 3: Application Process**

Completing this application is the first step in the process. Once your application has been received, you will receive a secure email (via OceanMD) with a questionnaire regarding your demographic information.

Once, we have received this information, you will receive a phone call to review your application and inform you of the wait time.

Incomplete applications will delay your intake process.

#### **Step 4: Your first appointment**

Your first meeting with your provider at the Centre will be a “meet and greet” appointment. 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.

You can also register with **Health Care Connect** by calling **1-800-445-1822** or registering online through <https://hcc3.hcc.moh.gov.on.ca/>

**We are experiencing high volumes of applications for primary health care providers at Grand River CHC. There is a wait time of 8 to 9 months for first appointments with a provider.**



363 Colborne Street Brantford ON. N3S 3N2  
intake@grchc.ca

The information requested on this form will help us assign you a primary care provider (doctor or nurse practitioner).  
We are collecting information from clients to find out what unique needs our clients have.  
We may use this information for statistical purposes but you will not be identified at an individual level.

## Primary Care Intake Form

### General Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Pronouns (check one):  He/Him/His  She/Her/Hers  They/Them/Their  
 Other (please specify): \_\_\_\_\_

Biological Sex (check one):  Male  Female  Intersex

Health Card #: \_\_\_\_\_ Version Code (letters): \_\_\_\_\_ Expiry: \_\_\_\_\_

Birth Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(dd) (mm) (yyyy)

Address: \_\_\_\_\_  
(Apt. #) (No. And Street) (City) (Postal Code)

Preferred Contact #: \_\_\_\_\_ Message allowed? Yes  or No

Back-up Contact #: \_\_\_\_\_ Message allowed? Yes  or No

Your email Address: \_\_\_\_\_

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 any emails regarding personal health information are sent over a secure system using OceanMD. I understand at this time, messages from GRCHC will not allow for any email response from me. GRCHC will not share your email address with any third party. **Please initial here:** \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone/Cell #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Please list all children under the age of 16 who need care at GRCHC (complete package for each child)

Name	Date of Birth	Relationship

**Health Care Providers**

Do you currently have a primary care doctor or nurse practitioner elsewhere? Yes  No

If YES, provide full name of doctor/nurse practitioner and the city where located: \_\_\_\_\_

If NO, by signing here you confirm you do not currently have a 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  No  If yes, please complete the following table:

Specialist Name	Reason for Visit	Date of Last Visit

**Medical History**

Have you been diagnosed with any medical conditions? Yes  No  If yes, please complete the following table:

Medical Condition (e.g. diabetes, high blood pressure, etc.)	Year Diagnosed

Are you or could you be pregnant? Yes  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  No

If yes, please indicate the reason for visit/admission: \_\_\_\_\_

Have you had any surgeries? Yes  No  If yes, please complete the following table:

Surgery	Year

**Current Medication**

Are you currently taking any medications? Yes  No  If yes, please complete the following table:

Prescribed Medications (name and dose)	Prescribed by
Over the Counter Medications	

Name of Pharmacy: \_\_\_\_\_ Location: \_\_\_\_\_

What language do you feel most comfortable speaking in with your health care provider? (check **one** only):

- |   |                                      |                                 |  |   |   |
|---|--------------------------------------|---------------------------------|--|---|---|
| <input type="checkbox"/> English                      | <input type="checkbox"/> French      | <input type="checkbox"/> Arabic | <input type="checkbox"/> Bengali                                 | <input type="checkbox"/> Chinese (Cantonese)  | <input type="checkbox"/> Chinese (Mandarin) |
| <input type="checkbox"/> Czech                        | <input type="checkbox"/> Dari        | <input type="checkbox"/> Farsi  | <input type="checkbox"/> Greek                                   | <input type="checkbox"/> Hindi                | <input type="checkbox"/> Hungarian          |
| <input type="checkbox"/> Italian                      | <input type="checkbox"/> Korean      | <input type="checkbox"/> Nepali | <input type="checkbox"/> Polish                                  | <input type="checkbox"/> Portuguese           | <input type="checkbox"/> Punjabi            |
| <input type="checkbox"/> Russian                      | <input type="checkbox"/> Serbian     | <input type="checkbox"/> Slovak | <input type="checkbox"/> Somali                                  | <input type="checkbox"/> Spanish              | <input type="checkbox"/> Tamil              |
| <input type="checkbox"/> Turkish                      | <input type="checkbox"/> Ukrainian   | <input type="checkbox"/> Urdu   | <input type="checkbox"/> Vietnamese                              | <input type="checkbox"/> ASL                  | <input type="checkbox"/> Mohawk             |
| <input type="checkbox"/> Cayuga                       | <input type="checkbox"/> Ojibway     | <input type="checkbox"/> Cree   | <input type="checkbox"/> Other Indigenous (please specify) _____ |   |   |
| <input type="checkbox"/> Other (please specify) _____ | <input type="checkbox"/> Do not know |                                 |  | <input type="checkbox"/> Prefer not to answer |   |

**Please read the following and initial each statement to provide your consent:**

- 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.
- I understand that my information will be kept confidential in accordance with the Personal Health Information Protection Act (PHIPA).
- Grand River CHC staff work as a team to provide services and I understand that I may work with more than one staff member.
- 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 about you to provide the best care/services possible.

**Thank you for completing this package. We will be in touch with you shortly to finalize your file. If you have any questions about this Client Intake Package, please call (519) 754-0777 ext. 255.**

## Client Rights and Responsibilities

### Client Rights:

Staff, students and volunteers will work as a team to ensure group participant needs are met. This will be accomplished by respecting the “client rights.”

A client of GRCHC has the right to:

- Feel welcome while at Grand River Community Health Centre
- Be treated in a considerate and respectful manner, where uniqueness is valued, and consideration is given to the client as a whole person
- Receive services and attend programs in a clean environment
- Have personal health information kept private and confidential
- Be informed about your care, have opportunities to ask questions and share your concerns to support you to make decisions about your care
- Accept or decline treatment and learn how doing so might impact your health
- Bring a support person to any appointment or request accommodation if needed
- Provide feedback

### Client Responsibilities:

Staff, students and volunteers commit to working in partnership with group participants. Clients are in turn expected to uphold certain responsibilities

A client of GRCHC is responsible to:

- Act in a way that allows other clients and our staff to feel safe
- Treat others with respect including respecting the gender, sexual orientation, ethnic, cultural and religious values of all GRCHC clients, visitors, volunteers, students and staff
- Attend and be on time for appointments and programs
- Share with us information necessary for your care including any changes in your contact information
- Be accountable for your actions
- Keep appointments, or cancel appointments in a timely fashion
- Inform reception or your service provider if you have cough, fever and/or flu-like symptoms
- Any behavior that is found to be abusive, threatening, and/or destructive may result in having the person leave and/or may be grounds for service restriction

**I have read and understood my rights and responsibilities as a client of the Grand River Community Health Centre.**

Client Name: \_\_\_\_\_ Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_