

# NEW PATIENT INTAKE FORM

Are you fully vaccinated for COVID-19? \_\_\_\_\_ Number of boosters received: \_\_\_\_\_

What is the current condition you will be seeing the Physician for on your visit?

\_\_\_\_\_

Surname \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Pronouns \_\_\_\_\_

Care Card Number \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Postal Code \_\_\_\_\_

Phone Number \_\_\_\_\_ Is this number long distance? \_\_\_\_\_

Email Address \_\_\_\_\_ Consent to Use? \_\_\_\_\_

Preferred Pharmacy \_\_\_\_\_ Address \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone Number for Emergency Contact \_\_\_\_\_ City \_\_\_\_\_

Name of Family Physician \_\_\_\_\_ City \_\_\_\_\_

Vaccinations received (ex. tdap, influenza, shingles, etc) \_\_\_\_\_

Medication Name and Dose	Date Started	Condition Treated
<input type="checkbox"/> N/A		

Allergy	Reaction	Requires Hospitalization ?	Onset
<input type="checkbox"/> N/A			

**THIS SECTION IS FOR ALL PATIENTS – PLEASE ASK STAFF TO WITNESS YOUR SIGNATURE.**

West Saanich Medical Clinic (Clinic) and staff of West Saanich Medical Clinic (Staff) have offered to communicate with you and other care providers using the following means of electronic communication: eFax, Email, searching electronic databases to which we have secure access, and keeping an electronic record about your care.

**Your privacy is of paramount importance to us.**

All our Staff (medical and others) MUST sign a privacy and confidentiality agreement as a condition of employment. Violation of the policy is considered grounds for dismissal.

**For fax, we use electronic fax within your electronic medical record (EMR) system.**

The faxes are sent and received within your electronic medical record, which is maintained on a secure server and accessible only by authorized personnel. eFax is a computer to computer form of communication. All transmission takes place on a dedicated virtual private network. Access is limited by password protection.

**Electronic Medical Records**

We maintain computerized medical record information about our encounters with you and about your health history. We use Med Access EMR, who keeps your data on their servers and backs up the data securely. When we communicate with their server we do so over a proprietary secure port.

**We search for data about you**

We also may need to look at information about you held by other health care providers. The relevant databases include but are not limited to: Pharmanet, a repository of prescriptions you have filled; Inteleviewer, a repository of diagnostic imaging; CareConnect, with laboratory data; and Powerchart, a database maintained by Island Health. The custodians of the above databases are responsible for their security. Only authorized persons can use them, only when needed for providing health care, and all are monitored and have audit trails.

**We communicate with others about you**

The Clinic or Staff that they delegate may also use electronic means to transmit information about you to others when it is medically appropriate using the above secure channels. Examples may include sending a photograph of a skin condition for a photo-dermatology consultation with a skin specialist, sending an eFax prescription to a pharmacy, or sending a referral letter to a specialist. Some electronic communication may be used other than for therapeutic purposes or to communicate clinical information. Where applicable, these communications will be limited to education, information, and administrative purposes.

**Receiving information about you**

We receive electronic communications about you through secure messages from other care providers including but not limited to specialists, laboratories, diagnostic facilities, and hospitals.

**By Entering my Information and Signing Below:**

I acknowledge that I have read and fully understand the risks, limitations, conditions of use, and instructions for use of the selected electronic communication services more fully described in this consent form.

I understand and accept the risks outlined in this consent form associated with the use of the services in communications with the West Saanich Medical Clinic and their Staff.

I consent to the conditions and will follow the instructions outlined, as well as any other conditions that the West Saanich Medical Clinic may impose on communications with you (the patient).

I acknowledge and understand that despite recommendations that encryption software be used as a security mechanism for electronic communications, it is possible that communications with the West Saanich Medical Clinic or their Staff using the Services may not be encrypted.

Despite this, I agree to communicate with the Clinic or Staff using these Services with a full understanding of the risk.

I also acknowledge that the Clinic or Staff, if so delegated, may communicate electronically with other care providers about my care when needed.

I acknowledge that either I or the West Saanich Medical Clinic may, at any time, withdraw the option of communicating electronically through the Services upon providing written notice. Any questions I had have been answered.

The information I have provided is true and to the best of my knowledge. I understand that copies of my visit with any doctors in this clinic will be sent to my family doctor and I consent to this. I understand that I must be respectful to the Physicians and staff at this clinic and will not engage in belittling, condescending, argumentative, bullying, yelling or other harassment to the Physicians and Staff at this clinic and if I engage in this type of behavior it may result in being refused treatment in this clinic excepting in a life-threatening emergency. I also consent to receiving treatment such as biopsies and procedures and that these procedures will have been fully explained to me including risks and options and I release any and all Physicians in this clinic from any liability that may arise from these procedures.

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Signature

Date

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Witness signature

Date