NEW PATIENT INTAKE FORM

Surname ______________________ First Name __________________ Middle Initial ______

Date of Birth (DD/MM/YY) __________________ Age _____ Pronouns _______________

Care Card Number ________________________________ Gender Identity ________________

Is your current gender identity different from your assigned gender at birth? (Y/N) ___________

If yes, please specify: ____

Address ______________________________ City _____________ Postal Code _____________

Home Phone Number _____________________ Cell Phone Number ________________________

Email Address _______________________________

Emergency Contact Name _________________________ Relationship _____________________

Phone Number for Emergency Contact ___________________ City ________________________

Preferred Pharmacy ______________________ Address __________________________________

Name of Family Physician (if applicable) ________________________ City ________________

Are you fully vaccinated for COVID-19? (Y/N) _____ Number of Vaccines Received: ________

Other Vaccinations Received: (i.e tdap, influenza, shingles)

Please include vaccine name, date received, and number of doses if applicable - If not applicable, please write N/A

Current Medications:

Please include medication name, dosage, frequency, and condition for treatment - If not applicable, please write N/A

Allergies:

Please include onset, reaction details, and whether it requires hospitalization - If not applicable, please write N/A

PATIENT INFORMATION AND CONSENT

West Saanich Medical Clinic and staff of West Saanich Medical Clinic have offered to communicate with you and other care providers using the following means of electronic communication: email, eFax, 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 of 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.

We use electronic fax (eFax) within our Electronic Medical Record (EMR) system.

The faxes we send and receive within our EMR are maintained on a secure server and accessible only by authorized personnel. eFax is a computer-to-computer form of communication. All fax transmission takes place on a dedicated virtual private network. Access to this network is limited by password protection.

Information about our Electronic Medical Records (EMR).

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 may also need to look at information about you that is 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 information), CareConnect (laboratory data), and PowerChart (a database maintained by Island Health). Only authorized persons can access and use them, and will do so only when needed for providing health care. All databases are monitored and have audit trails.

We communicate with others about you.

Our clinic or staff may also use electronic means to transmit information about you to others when it is medically appropriate to do so using the above mentioned 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.

We receive 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 the information on Page 1 and signing the form 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 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 these services may not be encrypted.

Despite this, I agree to communicate with the clinic or staff using these services with full understanding of the risk. I 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 West Saanich Medical Clinic may, at any time, withdraw the option of communicating electronically through the services mentioned above, upon providing written notice. Any questions that I have had have been answered at this time.

The information that 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 (if applicable) and I consent to this. I understand that I must be respectful to the Practitioners and staff at this clinic and will not engage in belittling, condescending, or argumentative behaviour, or any bullying, yelling, or other harassment to the Practitioners and staff at this clinic. If I engage in this type of behaviour it may result in being refused treatment in this clinic except 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 Practitioners in this clinic from any liability that may arise from these procedures.

Signature ______________________ Date ______________________