

PREAMBLE

The purpose of this document is to provide patients with information on what can be expected as a patient of Vancouver Family Practice Centre.

PRIVACY OF RECORDS

The patient understands that their medical records will be dealt with in accordance with the Personal Information Protection Act (PIPA).

COMMUNICATIONS

The patient authorizes Vancouver Family Practice Centre and its employees or agents to use email, telephone, and cellular phones, for communication regarding appointments and/or medical and health information. The patient understands that such communications may not be secure. If any information is received by a third party, it may no longer be protected by privacy legislation and may be disclosed by the person or entity that receives it.

USE OF EMAIL

The patient understands that if their email address is provided to the clinic, the clinic may send appointment reminders and other material related to treatment. The patient understands that email correspondence may not always be secure or private and the patient accepts this risk. The patient understands that email communication shall not be used to report urgent health care needs.

GOVERNING LAW AND JURISDICTION

The patient hereby agrees that the relationship and the resolution of any and all disputes arising from any investigations and treatment at the Vancouver Family Practice Centre Clinic by the physicians there shall be governed by and construed in accordance with the Laws of the Province of British Columbia and that the courts of the Province of British Columbia shall be the exclusive jurisdiction to entertain any complaint, demand, claim and cause of action whether based on alleged breach of contract or alleged negligence arising out of the treatment or investigations.

CONDUCT

Vancouver Family Practice Centre is committed to providing its staff with a safe, civil and respectful workplace. The patient acknowledges that the clinic may discontinue health services if the patient harasses, threatens, shows violent conduct, violates clinic property or shows other inappropriate conduct.

CANCELLATION AND NO-SHOW POLICY

We require 24 hours' notice for appointment cancellations and changes.

Patients who fail to arrive for a scheduled appointment or a late cancellation will result in a missed appointment/late cancellation fee.

The fees for a missed appointment/late cancellation are as follows:

- 15 minute appointments are \$45;
- 30 minute appointments are \$85.

Please note, if patients arrive late for their appointment, it is not guaranteed that your doctor will be able to see you.

POPULATION BASED FUNDING

Patients are registered with the clinic and the clinic is then funded to provide comprehensive primary care for patients on a quarterly basis.

We are able to provide extended clinic hours, same day urgent appointments, after hours care, on-call coverage, phone care when appropriate and Saturday clinics for urgent care.

To be eligible for registration, a patient must:

- be enrolled in MSP;
- live in the catchment area (Lower Mainland); and
- have a PHN.

Please be aware that if a registered patient at our clinic visits another family doctor outside of our practice, walk in clinic or TeleHealth Service, The Ministry of Health will deregister the patient from our practice.

An exemption to the above is, if a registered patient at our clinic visits a hospital emergency room, specialist's office or any other practitioner who we refer you to, or clinics outside of the Lower Mainland patients will not be deregistered from our clinic.

If the clinic receives a deregistration notification, patients will receive a deregistration warning notification. If after the warning notification patients still visit a family doctor outside of our clinic, walk in clinic or TeleHealth Service, patients will receive a deregistration confirmation notification from the clinic and no longer have access to our services.

The biggest advantage of this system is that as a registered patient, you have improved access to our entire health care team and our extended hours.

If you have any questions, please speak with our Clinic Manager.

PATIENT CONSENT TO ACCESS PharmaNet

The Province of British Columbia has established the provincial computerized pharmacy network and database known as "PharmaNet" pursuant to section 37 of the Pharmacists, Pharmacy Operations and Drug Scheduling Act, R.S.B.C. 1998, c. 363, and which may be continued pursuant to section 13 of the Pharmacy Operations and Drugs Scheduling Act, S.B.C., 2003, c.77. The patient authorizes any physician (and persons directly supervised by that physician) to access their personal health information contained within PharmaNet for the purpose of providing therapeutic treatment or care to the patient, or for the purpose of monitoring drug use. The patient understands and agrees that consent withdrawal must be in writing and delivered to the clinic's medical director.

PATIENT OR GUARDIAN

Patient or Guardian full name (printed)

Signature

Date

WITNESS

Witness full name (printed)

Signature

Date

Please Affix Patient Label Here

Personal Demographics:

Patient Name:			Date of Birth:	Gender:
Personal Health Number:	Home Phone:	Cell Phone:	Email*:	
Address:		City:	Province:	Postal Code:
Marital Status:		Spouse or Significant Other (Next of Kin): Please indicate relationship	Contact Phone Number:	
Occupation:	Handedness: (L or R)	Height:	Weight:	

Medical Information

Allergies: _____	Drug Allergies: _____	
Current Medications: _____ _____		
Tobacco Use: Yes / No / Never Packs/Day: Number of Years: Date Quit:	Alcohol Use: Yes / No / Never Type of Alcohol: Consumption/Week:	Recreational Drugs: Yes / No / Never Type: Use Amount/Week:
Do you exercise regularly? Yes / No	Type of exercise?	Amount per week?
How would you rate your diet? (please circle one)	Good	Fair Poor
What areas of your health would you like to improve (goals)? _____ _____		

*** By providing your email address, you consent to receiving communication regarding appointments and/or medical and health information. This consent can be withdrawn at any time in a written request. **INITIAL _____**

Medical History (cont)

Health Maintenance Screen: (Please answer as appropriate)

Last Eye Exam: Date: _____ Optometrist: _____

Last Dental Exam: Date: _____ Dentist: _____

Last Stool FIT/FOBT Test: Date: _____

Women:

Last Mammogram Date: _____ Results: Normal / Abnormal

Last Pap Smear Date: _____ Results: Normal / Abnormal

Obstetrical History (Pregnancies): G____ P____ T____ P____ A____ L____

Number of Pregnancies: _____

Number of Live Children: _____

Previous Surgeries (please list):

Survivorship: (Patients with a current or past history of cancer, please answer as appropriate)

Cancer Diagnosis: 1. _____ Date of Diagnosis: _____

2. _____ Date of Diagnosis: _____

Oncologist/Surgeon: 1. _____ 2. _____

Chemotherapy: 1. _____ Number of Cycles: _____ Last Dose: _____

Radiation: Yes / No Number of Treatments: _____ Last Treatment: _____

Hormone Therapy: Yes / No Hormone Name: _____ Start Date: _____

Last Chest X-Ray: _____ Last CT Scan: _____

Last PET Scan: _____ Last MRI: _____ Last Bloodwork: _____

PATIENT INTAKE QUESTIONNAIRE

Please complete the following:

Do you, or have you ever had any of these conditions? If so, please add details in the comments box.

Medical Condition:	Yes		No	Family History	Comments: (Please indicate dates of diagnosis or any treatments. If family history, please include the family member and history)
	Currently	Past			
Acne					
Addictions					
Anemia					
Anxiety					
Arthritis					
Asthma					
Blood Disorder (Clotting Disorder)					
Breast Disease					
Bronchitis					
Cancer					
Cholesterol Problems					
Depression					
Diabetes					
Digestive Problems					
Eating Disorders					
Eczema					
Fractures					
Gall Bladder/Liver Disease					

Questionnaire (cont.)

Medical Condition:	Yes		No	Family History	Comments: (Please indicate dates of diagnosis or any treatments. If family history, please include the family member and history)
	Currently	Past			
Glaucoma					
Hearing Loss					
Heart Disease					
Hepatitis					
High Blood Pressure					
HIV Infection					
Kidney/Bladder Infection					
Mental Health					
Migraines					
Pneumonia					
Sexually Transmitted Disease					
Speech Problems					
Stroke					
Thyroid or Endocrine Disease					
Tuberculosis					
Vision Problems					
Other Conditions:					