

## UNIFIED REFERRAL AND INTAKE SYSTEM (URIS) GROUP B APPLICATION (a)

Section I – To be completed by the community program

Review application, complete and sign in ink

The purpose of this form is to identify the child's specific health care <u>and</u> if applicable, apply for URIS Group B support which includes the development of a health care plan and training of community program staff by a registered nurse. URIS is a partnership of Health, Education and Family Services. If you have questions about the information requested on this form, you may contact the community program.

program (please $$ )						Col	Community Program Name:									Location of Service:     Same as on left														
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Section II - Child information - to be completed by parent																														
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Does your child have any of the following listed health concerns? $\Box$ YES $\Box$ NO (check $()$ one)																														
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□ Y	☐ YES ☐ NO Asthma (administration of medication by inhalation)																													
	<ul> <li>☐ YES ☐ NO</li> <li>☐ YES ☐ NO</li> <li>☐ Does the child bring reliever medication (puffer) to the community program?</li> <li>☐ Does your child know when to take their reliever medication (puffer) e.g. can recognize signs</li> </ul>										ano																			
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⊔ <b>Y</b>	<ul> <li>YES □ NO Seizure disorder What type of seizure(s) does the child have?</li> <li>□ YES □ NO Does the child require administration of rescue medication? □Lorazepam □Midazolam</li> </ul>																													
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I understand that any other collection, use or disclosure of personal information or personal health information about my child will not be permitted without my consent, unless authorized under FIPPA or PHIA.  Consent will be reviewed with me annually. I understand that as the parent/legal guardian I may amend or revoke this consent at any time with a written request to the community program.  If I have any questions about the use of the information provided on this form, I may contact the community program directly.  NAME (PRINT) Parent/ Legal Guardian  SIGNATURE Parent/Legal Guardian  DATE (YYYY/MMM/DD)  Mailing Address: City/Town: Postal Code:  Work/Daytime Phone: Cell Phone: Home Phone:	Unified R	eferral and	Intake System (UR	S) Group B Application								
YES   NO   Does the child require the established appliance to be changed at the community program?		$\square$ NO	Ostomy Care									
YES   NO   Does the child require the established appliance to be changed at the community program?   YES   NO   Does the child require assistance with ostomy care at the community program?   YES   NO   Does the child have a gastrostomy tube? Type of tube:   YES   NO   Does the child require gastrostomy tube feeding at the community program?   YES   NO   Does the child require gastrostomy tube feeding at the community program?   YES   NO   Does the child require administration of medication via the gastrostomy tube at the program?   YES   NO   Does the child require administration of medication via the gastrostomy tube at the program?   YES   NO   Does the child require assistance with CIC at the community program?   YES   NO   Does the child require assistance with CIC at the community program?   YES   NO   Does the child require assistance with CIC at the community program?   YES   NO   Does the child require assistance with CIC at the community program?   YES   NO   Does the child require assistance with CIC at the community program?   YES   NO   Does the child require assistance with CIC at the community program?   YES   NO   Does the child require assistance with CIC at the community program?   YES   NO   Does the child foreguire as a specialized emergency response at the community program?   YES   NO   Cardiac Condition where the child requires a specialized emergency response at the community program.   What type of cardiac condition has the child been diagnosed with?   YES   NO   Bleeding Disorder (e.g., von Willebrand disease, hemophilia)   What type of steroid dependence has the child been diagnosed with?   YES   NO   Steogenesis Imperfecta (brittle bone disease)   What type?   YES   NO   Ostoogenesis Imperfecta (brittle bone disease)   What type?   YES   NO   Ostoogenesis Imperfecta (brittle bone disease)   What type?   YES   NO   Ostoogenesis Imperfecta (brittle bone disease)   What type?   YES   NO   Ostoogenesis Imperfecta (brittle bone disease)   What type?   YES   NO   Ostoogenesis Imperfecta			$\square$ YES $\square$ NO	<del>_</del>								
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YES   NO   Does the child have a gastrostomy tube? Type of tuber:   YES   NO   Does the child require gastrostomy tube feeding at the community program?   YES   NO   Does the child require administration of medication via the gastrostomy tube teat the program?   YES   NO   Clean Intermittent Catheterization (CIC)   YES   NO   Does the child require color:   YES   NO   Does the child require assistance with CIC at the community program?   YES   NO   Does the child require assistance with CIC at the community program?   YES   NO   Pre-set Oxygen   YES   NO   Does the child bring oxygen equipment to the community program?   YES   NO   Suctioning (oral and/or nasal)   YES   NO   Does the child bring oxygen equipment to the community program?   YES   NO   Suctioning (oral and/or nasal)   YES   NO   Does the child bring oxygen equipment to the community program?   YES   NO   Cardiac Condition where the child requires as specialized emergency response at the community program.   YES   NO   Cardiac Condition where the child requires as specialized emergency response at the community program.   YES   NO   Bleeding Disorder (e.g., von Willebrand disease, hemophilia)   What type of bleeding disorder has the child been diagnosed with?   YES   NO   Endocrine Conditions (e.g. steroid dependence, congenital adrenal hyperplasia, hypopituitarism, Addison's disease)   What type of steroid dependence has the child been diagnosed with?   YES   NO   Osteogenesis Imperfecta (brittle bone disease)   What type?   Section III - Authorization for the Release of Medical Information   In accordance with The Personal Health Information Act (PHIA), authorize the Community program, the Unified Referral and Intake system Provincial Office, and the nursing provider; in recessary, for the purpose of developing and implementing an Individual Health Care Plan/Emergency Response Plan and training community program staff for   Child's Mane:   Child's Mane:   Child's Mane:   Child's Parent   Legal Guardian   Child with order the purposes of progra			☐ YES ☐ NO	Does the child require assistance with ostomy care at t	he community program?							
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YES   NO   Does the child require CIC?   Destrict of the community program?   Pre-set Oxygen   YES   NO   Does the child require assistance with CIC at the community program?   YES   NO   Does the child require pre-set oxygen at the community program?   YES   NO   Does the child bring oxygen equipment to the community program?   YES   NO   Does the child bring oxygen equipment to the community program?   YES   NO   Does the child bring oxygen equipment to the community program?   YES   NO   Does the child bring oxygen equipment to the community program?   YES   NO   Does the child bring suctioning equipment to the community program?   YES   NO   Cardiac Condition where the child requires a specialized emergency response at the community program.   What type of cardiac condition has the child been diagnosed with?   What type of such program   What type of such program   What type of such program   What type of bleeding disorder has the child been diagnosed with?   YES   NO   Endocrine Conditions (e.g. steroid dependence, congenital adrenal hyperplasia, hypopituitarism, Addison's disease)   What type of steroid dependence has the child been diagnosed with?   What type of steroid dependence has the child been diagnosed with?   YES   NO   Osteogenesis Imperfecta (brittle bone disease)   What type?   Section III - Authorization for the Release of Medical Information   In accordance with The Personal Health Information Act (PHIA), authorize the Community Program, the Unified Referral and Intake System Provincial Office, and the nursing provider serving the community program, all of whom may be providing services and/or nation yeelife shealth care provider, if necessary, for the purpose of developing and implementing an Individual Health Care Plan/Emergency Response Plan and training community program staff for   Child's PHIM:   Latisoa authorize the Unified Referral and Intake System Provincial Office to include my child's information in a provincial database which will only be used for the purposes of program plan				·	the gastrostomy tube at the program?							
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NAME (PRINT) Parent/ Legal Guardian     SIGNATURE Parent/Legal Guardian     DATE (YYYY/MMM/DD)       Mailing Address:     City/Town:     Postal Code:       Work/Daytime Phone:     Cell Phone:     Home Phone:					amena er reveke and concern at any							
NAME (PRINT) Parent/ Legal Guardian     SIGNATURE Parent/Legal Guardian     DATE (YYYY/MMM/DD)       Mailing Address:     City/Town:     Postal Code:       Work/Daytime Phone:     Cell Phone:     Home Phone:	If I have a	any questio	ns about the use of	the information provided on this form. I may contact the	community program directly							
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Original Effective Date: 2013-Dec Revised Effective Date: 2019-Oct-30