Unified Referral and Intake System (URIS) Group B Application

In accordance with Section 15 of *The Personal Health Information Act* (PHIA), the purpose of this form is to identify the child's health care intervention(s) and 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. If you have questions about the information requested on this form, you may contact the community program.

Section I – Community program information (to be completed by the community program)

Type of community program (please √)	
❑ School ❑ Licensed child care ❑ Respite ❑ Recreation program	Name of community program: Contact person: Phone: Fax: Email: Address (**location where service is to be delivered)**: Street: City/Town: POSTAL CODE:

Section II - Child information

Last Name **First Name** **Birthdate**

month (print) D D Y Y Y Y

Also Known As

Please check (√) all health care conditions for which the child requires an intervention during attendance at the community program.

❑ **Life-threatening allergy (and child is prescribed an EpiPen)**

Does the child bring an EpiPen to the community program? ☐ YES ☐ NO

❑ **Asthma (administration of medication by inhalation)**

Does the child bring asthma medication (puffer) to the community program? ☐ YES ☐ NO

Can the child take the asthma medication (puffer) on his/her own? ☐ YES ☐ NO

❑ **Seizure disorder**

What type of seizure(s) does the child have? _____

Does the child require administration of rescue medication (e.g., sublingual lorazepam)? ☐ YES ☐ NO

❑ **Diabetes**

What type of diabetes does the child have? ☐ Type 1 ☐ Type 2

Does the child require blood glucose monitoring at the community program? ☐ YES ☐ NO

Does the child require assistance with blood glucose monitoring? ☐ YES ☐ NO

Does the child have low blood sugar emergencies that require a response? ☐ 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? _____

❑ **Bleeding Disorder** (e.g., von Willebrand disease, hemophilia)

What type of bleeding disorder has the child been diagnosed with? _____

❑ **Steroid Dependence** (e.g., congenital adrenal hyperplasia, hypopituitarism, Addison's disease)

What type of steroid dependence has the child been diagnosed with? _____

❑ **Osteogenesis Imperfecta (brittle bone disease)**

❑ **Gastrostomy Feeding Care**

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 community program? ☐ YES ☐ NO

❑ **Ostomy Care**

Does the child require the ostomy pouch to be emptied at the community program? ☐ 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

❑ **Clean Intermittent Catheterization (IMC)**

Does the child require assistance with IMC at the community program? ☐ YES ☐ NO

❑ **Pre-set Oxygen**

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

❑ **Suctioning (oral and/or nasal)**

Does the child require oral and/or nasal suctioning at the community program? ☐ YES ☐ NO

Does the child bring suctioning equipment to the community program? ☐ YES ☐ NO

Section III - Authorization for the Release of Medical Information

I 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 supports to my child, to exchange and release medical information specific to the health care interventions identified above and consult with my child's physician(s), 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 name)

I also 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 planning, service coordination and service delivery. This database may be updated to reflect changing needs and services. I understand that my child's personal and personal health information will be kept confidential and protected in accordance with *The Freedom of Information and Protection of Privacy Act* (FIPPA) and *The Personal Health Information Act* (PHIA).

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.

_____ _____
Parent/Legal guardian signature Date

_____ _____ _____
Mailing Address Postal Code Phone number

Winnipeg Regional Health Authority | Office régional de la santé de Winnipeg

Dear Parent/Guardian

Please complete and sign the attached Asthma Standard Health Care Plan (SHCP) for your child and return it to the community program. This health care plan is completed <u>every year</u> so the staff has current health information about your child.

The Unified Referral and Intake System (URIS) is a joint initiative of the provincial government departments of Health, Education and Family Services. URIS provides support for children with specific health care needs (e.g., asthma, life-threatening allergies, diabetes, seizures) when they are attending school, child care facility or other community programs. When a child is approved for URIS support, a registered nurse develops a health care plan and provides training to community program staff. The Winnipeg Regional Health Authority (WRHA) provides URIS support in your child's school/child care facility.

Your child's community program has requested the WRHA to provide URIS support for his/her asthma. The attached Standard Health Care Plan (SHCP) has been established by URIS and was developed through consultation with clinical experts. It is the recommended practice for responding to an asthma episode in community program settings.

It is important that we work together to support your child's health care needs and we appreciate the time and information that you have provided. Once you have returned the attached plan to the school/child care facility, I will review it and call you if I have any questions. The plan will be used by the staff to guide their response if your child experiences difficulty with his/her asthma.

If you have any questions about completing the plan, please call me.

Angela Klassen
URIS Direct Service Nurse
975 Henderson Highway
Winnipeg, MB R2K 4L7
Phone: 938-5413
Fax: 938-5119
Email: aklassen4@wrha.mb.ca

Winnipeg Regional Health Authority | Office régional de la santé de Winnipeg

ASTHMA STANDARD HEALTH CARE PLAN (SHCP)

Child name:	**Gender:**	**Birth date:**
School/child care facility:		**Grade (if applicable):**
Parent/guardian name:		**MHSC:**
Primary Phone #:	**Secondary Phone #:**	**PHIN:**
Parent/guardian name:		
Primary Phone #:	**Secondary Phone #:**	
Alternate emergency contact name:		
Primary Phone #:	**Secondary Phone #:**	
Allergist:		**Phone #:**
Pediatrician/Family doctor:		**Phone #:**
Known allergies:		
Does child wear MedicAlert™ identification worn for asthma?	☐ **YES** ☐ **NO**	

TRIGGERS - List items that most commonly trigger your child's asthma.

RELIEVER MEDICATION (or bronchodilators) provides fast temporary relief from asthma symptoms. It is recommended that reliever medication is carried with the child so it is available if an asthma episode occurs.

What Reliever medication has been prescribed for your child? (CHECK ONE)	☐ Salbutamol (e.g. Ventolin®, Airomir®) ☐ Symbicort®	☐ Other _____
How many puffs of Reliever medication are prescribed for an asthma episode? (CHECK ONE)	☐ 1 puff ☐ 2 puffs	☐ 1 or 2 puffs ☐ other _____
Where does your child carry his/her Reliever medication? (CHECK ONE)	☐ fanny pack ☐ backpack	☐ purse ☐ other _____
Does your child know when to take their Reliever medication?	☐ Yes ☐ No	**Can your child take their Reliever medication on their own?** ☐ Yes ☐ No

CIRCLE the type of medication device your child uses for Reliever medication.


Metered dose inhaler (MDI)


MDI & spacer with mouthpiece


MDI & spacer with mask


Turbuhaler®


Diskus®

The Health Care Plan should accompany the child on excursions outside the facility.

Winnipeg Regional Health Authority | Office régional de la santé de Winnipeg

ASTHMA STANDARD HEALTH CARE PLAN (SHCP)

Name:	**Birth date:**

IF YOU SEE THIS: →	**DO THIS:**
Symptoms of asthma • Coughing • Wheezing • Chest tightness • Shortness of breath • Increase in rate of breathing while at rest	1. Remove the child from triggers of asthma. 2. Have the child sit down. 3. Ensure the child takes Reliever medication (usually blue cap or bottom). 4. Encourage slow deep breathing. 5. Monitor the child for improvement of asthma symptoms. 6. If Reliever medication has been given and asthma symptoms do not improve in 5-10 minutes, contact parent/guardian. • *Reliever medication can be repeated once at this time. If the child is not well enough to remain at the community program, the parent/guardian should come and pick them up.* 7. If any of the emergency situations occur (see list below), call 911/EMS.
Emergency situations • Skin pulling in under the ribs • Skin being sucked in at the ribs or throat • Greyish/bluish color in lips and nail beds • Inability to speak in full sentences • Shoulders held high, tight neck muscles • Cannot stop coughing • Difficulty walking	1. Activate 911/EMS. *Delegate this task to another person. Do not leave the child alone.* 2. Continue to give Reliever medication as prescribed every five minutes. 3. Notify the child's parent/guardian. 4. Stay with the child until EMS personnel arrives.

Signs that asthma is not controlled

If staff becomes aware of any of the following situations, they should inform the child's parent/guardian.

- Asthma symptoms prevent the child from performing normal activities.
- The child is frequently coughing, short of breath or wheezing.
- The child is using Reliever medication more than 3 times per week for asthma symptoms.

I have reviewed this health care plan and provide consent to this plan on behalf of my child.

Parent/guardian signature: _____ **Date:** _____

I have reviewed this health care plan to ensure it provides the community program with required information.

Nurse signature: _____ **Date:** _____

Documentation

☐ **Instruction sheet for medication device attached**