Unified Referral and Intake System (URIS) Group A 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) <u>and</u> apply for URIS Group A.

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Type of community							N	Name of community program:																										
program (please √)						С	Contact person:																											
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Please check ($$) all health care child requires an intervention community program.									e conditions for which the during attendance at the								Please check $()$ the support required by the child at the community program. Refer to the URIS Policy and Procedure Manual for additional information.																	
☐ Ventilator Car																	Registered nurse to perform health care procedure(s) required by child.																	
☐ Tracheostomy Care								e	•								Orientation/training for the registered nurse.														•			
☐ Suctioning (Tracheal/P									/Pharyngeal)								Coverage by an alternate registered nurse to allow the primary nurse to attend interdisciplinary planning meetings related to the child.																	
	Nasogastric tube care and/or feeding															ize nter				al e	equ	ıipı	mei	nt a	and									
Complex administrat via infusion pump, na injection (other than								, nas									Limited consumable health care items.																	
		Central or peripheral venous line intervention									Some transportation costs related to medical needs of child.													al										
	Other clinical interventions rec judgments and decision makin medical or nursing profession									ing	by					Auditory intercom system/pager/cell phone.																		
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Please attach a completed URIS Group B application if necessary.



Section III - Authorization for the Release of Medical Information

Mailing Address

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 <i>The Freedom of Information and Protection of Privacy Act</i> (FIPPA) and <i>The Personal Health Information Act</i> (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

Postal Code

Phone number