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 pro	ogram information (to be con	npleted by the community program)
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Type of community program (please $$)		Name of community program:								
		Contact person:								
	School	Phone:	Fax:							
	Licensed child care	Email:								
	Respite									
	Recreation program	Address (location where service is to be delivered):								
		Street:								
		City/Town:	POSTAL CODE:							

Section II - Child information

Last Name				First Name							Birthdate														
	•	1		11		I	I											mo	onth	(print)	D	D	Y١	()	Υ
Also Know	n As																								
Please check ($$) all health care conditions for which the child requires an intervention during attendance at the community program.																									
Life-th	Life-threatening allergy (and child is prescribed an EpiPen)																								
Does th	ne child	brin	g ai	n Ep	oiPe	n to t	he co	omr	nun	ity	prog	grar	n?							□ Y	ES		NO		
Asthma (administration of medication by inhalation)																									
Does th	e child	bring	g as	sthm	na m	edic	ation	(pu	ffer) to	the	со	mm	unit	y pi	rogr	ram	?		□ Y	ES		NO		
Can the	child ta	ake 1	the	asth	nma	med	icatic	n (p	ouffe	er)	on ł	nis/ł	ner	owr	?ר					□ Y	ES] NO		
Seizure disorder																									
What ty	What type of seizure(s) does the child have?																								
Does th	Does the child require administration of rescue medication (e.g., sublingual lorazepam)?																								
Diabetes																									
What ty	pe of di	abe	tes	doe	s the	e chi	d ha	ve?											[_ Ту	vpe '	1 🗌] Тур	be 2	2
Does th	e child	requ	iire	bloc	od gl	lucos	e mo	onito	oring	g at	t the	со	mm	uni	ty p	rog	ram	?	[S] NO)	
Does th	Does the child require assistance with blood glucose monitoring?																								
Does th	e child	have	e lo	w bl	ood	suga	ar em	erg	enc	ies	tha	t re	quir	e a	res	por	se?)			ΞS)	
Cardiac condition where the child requires a specialized emergency response at the community program.																									
What ty	What type of cardiac condition has the child been diagnosed with?							_																	
Bleeding Disorder (e.g., von Willebrand disease, hemophilia)																									
What ty	pe of bl	eed	ing	disc	ordei	r has	the o	chilo	d be	en	dia	gno	sed	wit	h? ⁻										-



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?									
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?									
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?									
Does the child bring suctioning equipment to the community program?									

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