PMH089



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 $$)					mmunity Program Name:								Location of Service: Same as on left																			
	School					Contact person:										Contact person:																
							Phone: Fax:										Phone: Fax:															
	Respite Email:															Email:																
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☐ Other:			City/Town:									Street address: City/Town:																				
					-	Postal Code:									Postal Code:																	
Section II - Child information - to be completed by parent																																
Last Name								First Name									Birthdate															
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Preferred Name (Alias) Age Grade Gender																																
Preferred Name (Alias) Age Grad							aut	M F Other																								
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Does your child ride the bus? ☐ YES ☐ NO																																
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		at	the co	omm	unity	prog	gra	am.	Ret	urn ti	ne co	om	nple	etec) tc	orm	to t	ne	СО	m	mu	ını	ty p	orog	gra	am.						
☐ YES ☐ NO Life-threatening allergy and child is prescribed an injector (e.g. Epi-Pen®/)/ T	aro	Epir	neph	rine	· ®/																				
Allerject®)																																
					YES	\square N	0		Does	the c	hild b	rin	g ar	n inj	ecto	or to	the	cor	nmı	uni	ity p	oro	grar	n?								
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☐ YES ☐ NO Does the child bring reliever medication (puffer) to the community prog							_																									
					YES		0			your thma?		kno	ow <u>v</u>	whe	<u>n</u> to	o tak	e th	eir	relie	eve	er m	nec	licat	ion	(pı	uffei	r) e.(g. ca	n rec	ogni	ze si	gns
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☐ YES ☐ NO Does the child require administration of rescue medication? ☐ Lorazepam ☐ Midazola								am																								
					YES			Does the child require the use of a vagal nerve stimulator (wand)?																								
□ Y	ES		□ NO		iabet			hat														•	-									
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Original Effective Date: 2013-Dec File in Page 1 o									1 of 2																							

Unified Referr	ral and Inta	ke System (URI	S) Group B Application								
	NO O	stomy Care									
		YES □ NO	Does the child have an ostomy/stoma?								
		☐ YES ☐ NO 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 ch								
		☐ YES ☐ NO Does the child require assistance with ostomy care at the community program?									
	NO G	astrostomy C	are								
		YES □ NO	Does the child have a gastrostomy tube? Type of tube: _								
		YES □ NO	Does the child require gastrostomy tube feeding at the co								
		YES 🗆 NO	Does the child require administration of medication via the	ne gastrostomy tube at the program?							
	NO C	lean Intermitt	ent Catheterization (CIC)								
		□ YES □ NO Does the child require CIC?									
		YES 🗆 NO	Does the child require assistance with CIC at the commu	unity program?							
	NO P	re-set Oxyger	1								
		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 S	uctioning (ora	al and/or nasal)								
		YES □ NO	Does the child require oral and/or nasal suctioning at the	community program?							
		YES □ NO	Does the child bring suctioning equipment to the commu	nity program?							
☐ YES ☐	NO C	ardiac Condit	ion where the child requires a specialized emerg	ency response at the							
	C	ommunity pro	gram.								
	W	hat type of card	iac condition has the child been diagnosed with?								
☐ YES ☐	NO B	leeding Disor	der (e.g., von Willebrand disease, hemophilia)								
		_	ding disorder has the child been diagnosed with?								
☐ YES ☐			ditions (e.g. steroid dependence, congenital adre	enal hyperplasia.							
			n, Addison's disease)	, p p,							
	-		oid dependence has the child been diagnosed with?								
□ YES □		-	mperfecta (brittle bone disease) What type?	-							
	110 0	<u>steogenesis i</u>	imperiecta (brittle bone disease) What type:								
Section III	- Author	ization for th	ne Release of Medical Information								
			Information Act (PHIA),I authorize the Community Program g provider serving the community program, all of whom ma								
			blease medical information specific to the health care interv								
with my child's	s health ca	re provider, if ne	ecessary, for the purpose of developing and implementing								
Plan/Emergen	ncy Respor	nse Plan and tra	ining community program staff for								
Child's Name			Child's PHIN:								
			Intake System Provincial Office to include my child's inform								
			gram planning, service coordination and service delivery. Inderstand that my child's personal and personal health inf								
			om of Information and Protection of Privacy Act (FIPPA) as								
(PHIA).											
I understand t	that anv oth	ner collection, us	se or disclosure of personal information or personal health	information about my child will not be							
			thorized under FIPPA or PHIA.	,							
Consent will b	ne reviewed	d with me annua	lly. I understand that as the parent/legal guardian I may a	mend or revoke this consent at any							
		st to the commu									
If I have any o	guestions a	bout the use of	the information provided on this form, I may contact the co	mmunity program directly.							
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NAME (PRIN	T) Parent/	Legal Guardian	SIGNATURE Parent/Legal Guardian	DATE (YYYY/MMM/DD)							
Mailing Addre	ess:		City/Town:	_ Postal Code:							
			Cell Phone:								
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Original Effective Date: 2013-Dec Revised Effective Date: 2019-Oct-30