Interior Health

Consent for Release of Confidential Information for use by Outreach Urban Health

Date: _____

Name of Client: _____

Date of Birth: _____

Written Consent

I _____hereby authorize Outreach Urban Health Staff (i.e. physician, nurse, SW, psychiatrist) to share/discuss pertinent information from my health record with the following community agencies when it is in the best interest of my care;

- ❑ Living Positive
- ❑ Ministry of Social Development
- ❑ Other (please name) _____
- ❑ Other (please name) _____

Information shared/discussed may include my medical treatment, diagnosis and/or case history and will be for the purposes of case planning, community referral, case conferencing and/or, information gathering.

I would like the following restrictions or limitations placed on the release of information:

_____

_____

This consent is valid for ____ years/months/days and will expire on_____.

_____
Name of Person Giving Consent

_____ _____
Signature of Person Giving Consent Date

_____ _____
Witness Date

****Consent may be revoked at any time by submitting a "Provision to Revoke Consent" form to Outreach Urban Health****

Interior Health

Provision to Revoke Consent

I _____ hereby revoke authorization for the release of any information, for the purposes and dates as stated above.

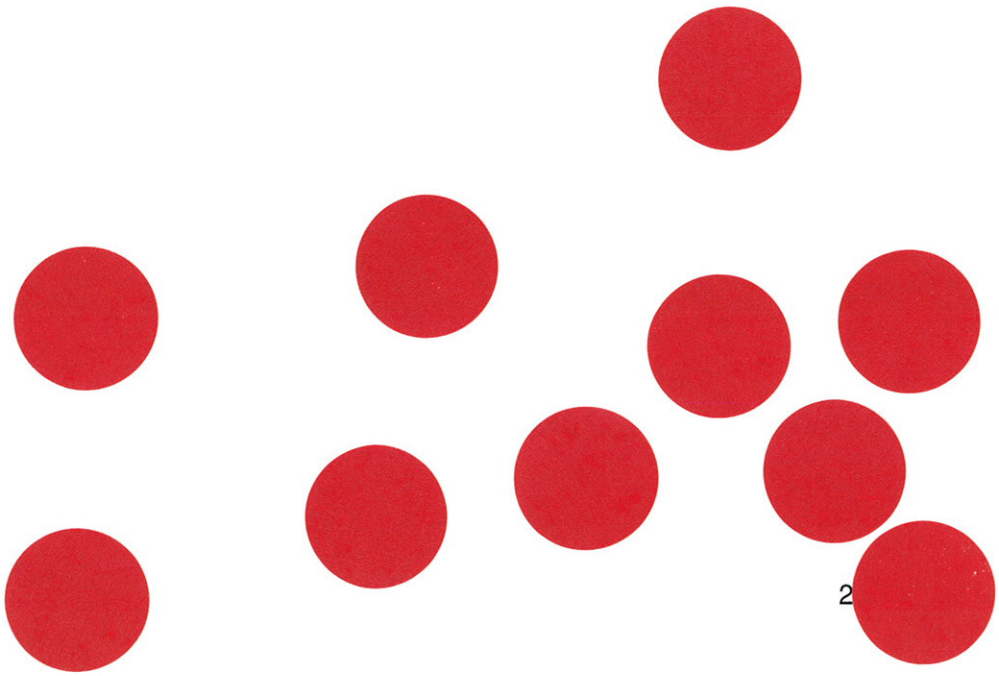
_____
Name of Person Giving Consent

_____ _____
Signature of Person Giving Consent Date

_____ _____
Witness Date

Please inform an OUH staff member directly and provide them with a copy of the Signed Revoke Consent form for their records. Thank you.

Copies to: Client (representative or guardian) and OUH Chart.



Interior Health

Outreach Urban Health
Immuno-deficient Client
Nursing Flow Sheet

Date: _____

Printed Information:
☐ Pharmanet
☐ iPHIS (Health Passport)

CLIENT IDENTIFICATION

Reason for Visit: ☐ Unwell ☐ Routine ☐ Other: _____

Mood _____ Dreams _____ Adherence _____ Missed Doses _____

Weight: _____kg Height:_____cm B/P: _____ Resp:_____ Pulse: _____ O2: _____ Temp: _____

Routine Investigations

LMP: _____ ☐ Bone Density (over 50)
Last PAP: _____ ☐ Chest X-ray
Last STI Screen: _____
Last Mammogram: _____
Pregnancy Test: _____
Testicular Health: _____
Rectal Exam: _____
Dental Exam: _____
Cigarettes: _____
Substance Use: _____

Blood Tests

☐ Routine CD4/VL **(Q1,Q3)** ☐ Hep A/B/C, RPR, toxo ***Do not order if immune**

☐ Urine Drug Screen **(PRN)** ☐ Urinalysis (Alb/Cr) **(Q3)**

☐ HIV resistance/genotype **(PRN) (Once)** ☐HLA B5701 **(prior to Abacavir** med change)

☐ Other: _____
(ALT,AST,CR,GFR) **(Q1, Q3)**
(Cholesterol)
Lytes

Systems: ☐ Cardiac ☐ Respiratory ☐ Liver/Hepatic (AST, ALT) ☐ Renal (CR/GFR) ☐ **Skin** ☐ **GU/Gyne**

Vaccinations Due: **Refer to iPHIS:**
☐ Hepatitis A ☐ Hepatitis B ☐ Flu Shot ☐ Pnuemovax
☐ Tetanus/Dip ☐ Meningococcal C ☐ TB Skin Test

Opportunistic Infection Medications/Prophylaxis - History:

Med: _____ **Start:** _____ **Stop:** _____
Med: _____ **Start:** _____ **Stop:** _____
Med: _____ **Start:** _____ **Stop:** _____

OI: _____ **When:** _____Hospital?: ☐ Yes ☐ No LOS: _____
(Last 12 months)

Follow-up Appointments	**Date**	**Time**
Doctor:		
Nursing:		
Social Worker:		
Addictions Counsellor:		

Transportation Requests? ☐ Yes ☐ No _____

****VERIFY CONTACT INFORMATION****

Patient's Cell Number: _____ ☐ OK to leave message

Home or Message Number: _____ ☐ OK to leave message

Notes: _____

Reason for Visit: ☐ Unwell ☐ Routine ☐ Other: _____

HIV Risk Factor: ☐ IV ☐ MSM ☐ Unknown Discordant Partner: ☐ Yes ☐ No ☐ Male ☐ Female

Most recent blood work? Date: _____ CD4= _____ HIV viral load_____
Nadir: _____ Seroconversion: _____
Baseline HIV Bloodwork:
HBsAg: _____ HBsAb:_____ HBcAb: _____
AnitHAV: _____ HCVAb: _____ Toxoplasmosis:_____
RPR: _____ HLA-B5701: _____

Currently on ARVs? ☐ No ☐ Yes If yes, specify: _____
Adherent: ☐ Yes ☐ No Missed Doses? _____
Other medications: _____
_____
_____
Allergies: _____

Most Recent Test Dates:
STI Screen: _____ **Pap:** _____ **Mammogram:** _____
Preg Test: _____ **Chest X-ray:** _____ **Testicular:** _____
Dental Exam: _____ **Eye Exam:** _____ **Rectal Exam:** _____

Current/History Opportunistic Infections:

Date:_____ OI: _____ Hosp: ☐ Yes ☐ No
Date:_____ OI: _____ Hosp: ☐ Yes ☐ No
Date:_____ OI: _____ Hosp: ☐ Yes ☐ No

Medical History: _____
_____
_____
_____
_____

Vaccination History:
☐ Hepatitis A Date: _____ ☐ Pnuemovax (Q 5yr) Date: _____
☐ Hepatitis B Date: _____ ☐ Flu Shot (Q yr) Date: _____
☐ Tetanus/Dip Date: _____ ☐ Meningococcal C Date: _____
☐ TB Skin Test (Q yr) Date: _____ ☐ **Waiting for transfer of records**

Follow-up Appointments	**Date**	**Time**
Doctor: _____	_____	_____
Nursing: _____	_____	_____
Social Worker: _____	_____	_____
Addictions Counselor: _____	_____	_____

Clinic Orientation
HIV education and support services:
☐ Offer CD4 / VL/ newly diagnosed booklets
☐ Websites advised (i.e. NAM, CATIE, AIDSMAP)
☐ Discuss legal requirements regarding disclosure
☐ Newly diagnosed courses

Self-care: ***Offer Calendar****
☐ CD4 / VL
☐ Blood requisitions Q 1-2 monthly at lab, prior to clinic visit
☐ Nurses appointments = 1/month; vaccines, yearly PAP/STI
☐ Regular Drs Appointments
☐ Eye Appt (Q year/optho) ☐ Dental Appt (Qualify GMDC?)

Referrals: ☐ **Social Work** ☐ **A & D** ☐ **Other:** _____

Intake completed by: _____
Notes: _____
_____

Interior Health

Outreach Urban Health
Immuno-deficient Client
First Contact Assessment

Date: _____

Printed Information:
☐ Pharmanet
☐ iPHIS (Health Passport)

CLIENT IDENTIFICATION

Date of Diagnosis: _____ ☐ New Diagnosis

Current GP: _____ ☐ Transfer – Previous Provider: _____

Consent Releases: ☐ Medical Record Consent – From: _____
☐ Pharmanet Consent (verbal)
☐ **Community Consent** ☐ **Recent Bloodwork?** _____

Type of Accommodation

☐ House/Apartment ☐ Shelter
☐ Treatment/Recovery House ☐ NFA
☐ Staying with family/friend ☐ Other

_____

Medical Coverage:

MSP: ☐ Yes ☐ No ☐ Other Health Insurance:

_____

Med: ☐ Pharmacare ☐ Plan G ☐ Other:

_____

Employment / Income Information

☐ Employed full-time
☐ Employed part-time
☐ Disability Income (PWD, CPP, etc.)
☐ Social Assistance
☐ Nutritional Supplement (MSD)
☐ Transportation Subsidy (MSD)
☐ Financial Support from partner/family
☐ Other: _____

Residency:

☐ BC - How long: _____
☐ Other: _____

Ethnicity: ☐ Aboriginal ☐ First Nations ☐ Status

Social Support and Service Utilization

☐ Partner/Family/Friends
☐ Living Positive
☐ Other:
☐ Case Manager:

How would you rate your mood (1-10)? _____

Would you benefit from a Mental Health Assessment? ☐ Yes ☐ No

Mental Health Diagnosis: ☐ Yes ☐ No _____

MRC: _____

Active/History of Substance Use: ☐ Smoking _____
☐ Alcohol _____
☐ Drugs _____

PATIENT CONTACT INFORMATION

Patient's Cell Number: _____ ☐ OK to leave message

Home Number: _____ ☐ OK to leave message

Patient address: _____ ☐ OK to send letters

_____

Emergency Contact: _____ ☐ OK to phone

_____ Are they aware of patients HIV status

_____ ☐ Yes ☐ No

Signature: _____ **Printed Name:** _____

We want to hear from you...

PATIENT SATISFACTION SURVEY – CONFIDENTIAL – NO NAME REQUIRED

Please take a moment to let us know how we are doing. After you have completed the survey, please place it in the Survey Drop Box.

PATIENT ACCESS SURVEY

1. **How would you rate your satisfaction with getting through to the office (either by phone or in person)?**

   ( ) Excellent ( ) Very Good ( ) Good ( ) Fair ( ) Poor

2. **How would you rate your satisfaction with the length of time you waited to get your appointment today?**

   ( ) Excellent ( ) Very Good ( ) Good ( ) Fair ( ) Poor

3. **How would you rate your satisfaction with the personal manner of the person you saw today (courtesy, respect, sensitivity, friendliness)?**

   ( ) Excellent ( ) Very Good ( ) Good ( ) Fair ( ) Poor

4. **How would you rate your satisfaction with the time spent with the person you saw today?**

   ( ) Excellent ( ) Very Good ( ) Good ( ) Fair ( ) Poor

5. **Did you see the clinician or staff member that you wanted to see today?**

   ( ) Yes ( ) No

6. **What services do you use at Outreach Urban Health?**

   ( ) Doctor ( ) Nurse ( ) Social Work ( ) A & D Counsellor ( ) Psychiatrist

   ( ) Chiropractor ( ) Podiatrist ( ) Acupuncture

What do you like about OUH? What could we improve?

_____

_____

_____

_____

_____

Please do tests as checked
Q 4 Months
Chlamydia & Gonnorhea - urine
Chlamydia & Gonnorhea - swabs (include location)
BV, Yeast , Trich (1 swab each)
HIV
HAV sAB; HBV sAg/sAb; HCV sAB

Please do tests as checked
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