Welcome to the Smiths Falls Nurse Practitioner-Led Clinic

Clinic Hours: Monday to Wednesday 9-4, Thursday 9-7:00, Friday 9-4
Phone: 613-205-1025 Fax: 613-205-1026
Website: www.smithsfallsnplc.com

We want to know if you've been hospitalized!

Please call the clinic if you have been admitted to a hospital. We want to ensure we follow up with you within 7 days of your discharge; whether it is a phone call from one of our nurses to see how you are doing, or a scheduled appointment with your health care provider. Please advise the hospital of the name of your nurse practitioner, as well as the name of the clinic, upon your hospital admission.

Specialists

If you are currently seeing a specialist, please give them name of your nurse practitioner, as well as the name of the clinic.

Self-Refer To our Allied Health Professionals

You can always call the clinic and book an appointment to see the dietitian, pharmacist, and social worker.

Medication Renewals

Please allow 7 days for prescription renewals. In most situations you can ask your pharmacist to fax us a prescription renewal request when your last refill. This way, your nurse-practitioner has time to renew your medication. This minimizes the chances of running out of medication also.

ER Visits

Use the emergency room for emergencies only! If you're not sure whether you should go to the ER or our clinic, please call the clinic and we will have you speak to one of our nurses who can advise you.
If you do visit the ER, please give them the name of your nurse practitioner and that they are located at the Smiths Falls Nurse Practitioner-Led Clinic.

Appointment Cancelations

Clients who cannot attend their scheduled appointment are required to give the clinic at least 24 hours' notice. This allows the appointment time to be offered to another client. We follow up with all clients who fail to provide notice to cancel, or who don't show up for their scheduled appointment.

If you Run Late…

We know that things can happen that we don't expect. If you are going to be late for your appointment, please call ahead if you can. If you are more than 10 minutes late for your scheduled appointment, reception will help you to reschedule your appointment for another time.

Smiths Falls
Nurse Practitioner-Led Clinic
52 Abbott St, Unit 5
Smiths Falls, ON, K7A 1W3

Phone:613-205-1025 ext: 5
Fax: 613-205-1027
Email: support@smithsfallsnplc.com

Intake Package Adult

Date:_____

_____	_____	_____	_____
First Name	**Initial**	**Last Name**	**Preferred Name**

Date of Birth: MM__DD___YYYY_____

Identify as: □ Male □ Female □ Two Spirit □ Other:_____

Health Card Number:_____Version Code____Expiry Date:_____

Do you have prescription drug coverage? □ Yes □ No

What is your preferred pharmacy?_____

Who referred you to our Clinic? _____

Mailing Address:_____

_____	_____	_____
City	**Province**	**Postal Code**

_____	_____	_____
Preferred Telephone	**Business/work Telephone**	**Cell/Other Telephone**

☐**When necessary, I give consent for Smiths Falls N.P.L.C. to leave a message on my phone asking me to return a phone call.**

Email Address: _____

NEXT OF KIN/POA PERSONAL CARE ONLY

_____ _____

Emergency Contact Name Relationship

_____ _____

Home Telephone Cell Phone

EMERGENCY CONTACT INFORMATION

☐ **Same as above**

_____ _____

Emergency Contact Name Relationship

_____ _____

Home Telephone Cell Phone

Who was your previous Physician/Nurse Practitioner? _____

Address/Phone#: _____

When did you last see your previous Physician/Nurse practitioner? _____

Are you seeing a Specialist? □ Yes or□No. If yes, please provide:

Name	Specialty	Address	Phone

Why are you seeing this specialist?

_____

_____

The following questions are asked to collect information pertaining to the determinants of health: Ethnicity: _____

Education:(Check highest level of achievement):
□ Grade School □ High School □ College □ University

Occupation/Previous Occupation: _____

Employment Status: □ Full time □ Part time □ Retired □ Unemployed □ Self Employed

Marital Status: □ Single □ Married □ Common Law □ Separated □ Divorced □ Widowed

Names and Ages of Children:

Name	Age	Name	Age

Exercise/Activity:

Type	How many minutes/day	How many days/week

Do you smoke or use tobacco (cigarettes, vaping, cigars, chewing tobacco or pipe smoking)?
□YES □NO
If you don't smoke but used to: Start date_____ End date:_____ Cigarettes/day_____
If you smoke now, how many years have you been smoking? _____
How many per day? _____
Are you interested in quitting? _____

Do you drink alcohol? □YES □NO
How many drinks per week? _____
Are you interested in quitting? _____

Do you currently use recreational drugs? □YES □NO
If yes, please specify type: _____
Have you considered stopping? _____

Do you currently drink caffeinated beverages such as coffee, tea, pop or energy drinks?
□YES □NO
If yes, how many per day_____

How would you rate your stress level from 1 to 10? _____
(1 being the lowest to 10 being the highest)

Do you ever have difficulty making ends meet at the end of the month?
□YES □NO

Have you filled out and sent in your tax forms?
□YES □NO

Allergies: □YES □NO

Allergy to Meds	Type of Reaction	Food/Environment	Type of Reaction

Do you carry an Epipen? □YES □NO
Do you wear a medical alert? □YES □NO
Have you ever had allergy testing? □YES □NO

What (if any), are your current health concerns/issues?
1._____
2._____

Vaccination History: Please attach a copy of immunization record.

□ DPT/TD (Tetanus) mm_____yyyy_____
□ Tuberculosis Test mm_____yyyy_____Result _____
□ Influenza mm_____yyyy_____
□ Pneumonia/Prevnar vaccine mm_____yyyy_____
□ Shingles vaccine mm_____yyyy_____
□ COVID-19 Vaccine Yes_____ No_____
1st Dose: Date_____ Brand_____
2nd Dose: Date_____ Brand_____

Childhood Illness:

□ Asthma □ Chickenpox □ Ear Infections □ Measles □ Mumps □ Rubella

Other (Description) _____

Past Medical History:

□ Arthritis	□ Asthma	□ Anemia	□ Anxiety
□ Back Pain	□ Bronchitis	□ Cancer	□ Chest Pain
□ Chronic Pain	□ Constipation	□ Depression	□ Diabetes
□ Diarrhea	□ Headaches	□ Heartburn	□ Heart Attack
□ Heart disease/Angina	□ Hepatitis	□ High Cholesterol	□ Seizures
□ High Blood Pressure	□ HIV/AIDS	□ Migraines	□ Kidney Problem
□ Osteoporosis	□ Sinus Problems	□ Incontinence	□ Stroke/TIA
□ Thyroid Problems	□ Other:_____		

#: Pregnancies_____Live Births____Miscarriages_____Abortions ____

Surgical History

□ Appendectomy (year_____)	□ Hernia Repair (year_____)
□ Breast Surgery (year_____)	□ Hip Replacement (year_____)
□ Bypass Surgery (year_____)	□ Hysterectomy (year_____)
□ Carpal Tunnel Release (year_____)	□ Knee Replacement (year_____)
□ Cataract Surgery (year_____)	□ Prostate Surgery (year_____)
□ Removal of Gallbladder (year_____)	□ Tonsillectomy (Year_____)

□ Other (Description and Year) _____

Preventative Screening History:

Date of Last: Colon cancer screening test _____ Colonoscopy_____
Pap smear_____ Mammogram_____
Bone Mineral Density_____
Lung Cancer Screening _____

Medications/Supplements:

Medication	Reason

Please attach a list from your pharmacy!

Family History of Illness: **(heart disease, heart attack, stroke, high blood pressure, diabetes, high cholesterol, cancer/ location, mental health-depression, schizophrenia, bipolar, obsessive compulsive disorder)**

	Living	Age at Diagnosis/Age at death	Diagnosis/Cause of Death
Daughter	□Yes □No	_____ _____	_____
	□Yes □No	_____ _____	_____
Son	□Yes □No	_____ _____	_____
	□Yes □No	_____ _____	_____
Mother	□Yes □No	_____ _____	_____
Maternal Grandmother	□Yes □No	_____ _____	_____
Maternal Grandfather	□Yes □No	_____ _____	_____
Father	□Yes □No	_____ _____	_____
Paternal Grandmother	□Yes □No	_____ _____	_____
Paternal Grandfather	□Yes □No	_____ _____	_____
Sister	□Yes □No	_____ _____	_____
	□Yes □No	_____ _____	_____
Brother	□Yes □No	_____ _____	_____
	□Yes □No	_____ _____	_____

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CONSENT TO THE COLLECTION, USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

At the Smiths Falls Nurse Practitioner-Led Clinic, your main health care provider will be a Nurse Practitioner. A Nurse Practitioner is a Registered Nurse with advanced training and skills in the areas of health assessment, diagnosis, and treatment of common episodic illnesses as well as chronic disease. The Nurse Practitioner works within a scope of practice set forth by the College of Nurses of Ontario, whereby she/he is able to order certain lab and diagnostic tests, order and/or renew medications, and diagnose illnesses. The Nurse Practitioners work collaboratively with a consulting physician.

I,_____understand that the Smiths Falls Nurse Practitioner-Led Clinic will only collect, use and disclose my personal health information with my consent unless a particular collection, use or disclosure is permitted or required by law without my consent.

I understand that I may revoke my consent any time by writing to the Smiths Falls Nurse Practitioner-Led Clinic.

The Smiths Falls Nurse Practitioner-Led Clinic takes your privacy seriously. All employees have signed a confidentiality agreement permitting them to access your personal information only when required for the provision of health service. The Smiths Falls Nurse Practitioner-Led Clinic has a comprehensive privacy policy posted in the waitingarea.

I hereby authorize Smiths Falls Nurse Practitioner-Led Clinic to be my health care provider, in doing so I give my consent for the clinic to collect, use and disclose my personal health information for the purposes that I have indicated above.

Name: _____

Signature: _____

Date: _____

The below consent will be discussed at your initial Meet and Greet appointment.

Please complete your previous primary care Physician/Nurse Practitioner name and clinic information and sign the bottom. We will only send this request once you have had your Meet and Greet appointment and have been accepted as a client at our clinic.

Authorization to Obtain Personal Health Information
Pursuant to the Personal Health Information Protection Act, 2004 (PHIPA)

I, _____, authorize_____
(Print your name) *(Print name of previous health care provider)*

(*Address/Phone # of previous provider*_____)

to disclose

☐ my personal health information consisting of:

_____

_____
(Describe the personal health information to be disclosed)

or

☐ the personal health information of _____
(Name of person for whom you are the substitute decision-maker)*

consisting of:_____

_____
(Describe the personal health information to be disclosed)

To: *The Smiths Falls Nurse Practitioner-Led Clinic*
52 Abbott Street, Unit 5,
Smiths Falls, Ontario K7A 1W3
Phone: 613-205-1025 Fax: 613-205-1026

I understand the purpose for disclosing this personal health information to the person noted above. I understand that I can refuse to sign this consent form.

Place Client Sticker Here

Client Signature:_____Date:_____

Witness Name:_____Date:_____

Witness Signature: _____

***Please note: A substitute decision-maker is a person authorized under PHIPA to consent, on behalf of an individual, to disclose personal health information about the individual.**