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

Newborn to 4 Months

Date:_______________

_______________ ______ ____________________ ____________________
First Name **Initial** **Last Name** **Preferred Name**

Date of Birth: MM_____DD____YYYY_____ **Gender:** ☐ **Male** ☐ **Female**

Health Card Number:________________Version Code_____Expiry Date:_________
MM/DD/YYYY

Mailing Address: ____

_____________________ _____________________ ________________________
City Province Postal Code

Parent Information

Mother's First name: ____________________ **Last:** ___________________________

Primary #: ____________________ **Cell#:** ___________________________

Mailing Address (if not same as child's) ____

Father's First name: _____________________ **Last:** ___________________________

Primary #: ____________________ **Cell#:** ___________________________

Mailing Address (if not same as child's) ____

Which Pharmacy is used? ____

Delivery Physician/Midwife____

Gestational Age: ____________

Vaginal_______**C-Section**________**Reason:** _____________________________

Complications at birth_____**Yes**_____**NO**

If yes, please describe ____

Birth Weight_________**grams**______**lbs**_____**oz**

Discharge Weight__________**grams**_______**lbs**_____**oz**

Length________**cm**________**inches** **Head Circumference**_______**cm**_______**inches**

APGAR Score: (1min)___________**(5min)** __________

Hearing Test: Pass________**Fail**_______**Right**_______**Left**

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

	Living	**Age at Diagnosis/Age at Death**		**Diagnosis/Cause of Death**
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	__________	__________	____________________
Brother	___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 waiting area.

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: ____________________________________