Unified Referral and Intake System (URIS) Group A 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 A.

Section I – Community program information (to be completed by the community program)

Type of community program (please √)	
☐ School	Name of community program:
☐ Licensed child care	Contact person:
☐ Respite	Phone: Fax:
☐ Recreation program	Email:
	Address (**location where service is to be delivered**): Street: City/Town: POSTAL CODE:

Section II - Child information

Last Name **First Name** **Birthdate**

month (print) D D Y Y Y Y

Also Known As

Please check (√) all health care conditions for which the child requires an intervention during attendance at the community program.	Please check (√) the support required by the child at the community program. Refer to the URIS Policy and Procedure Manual for additional information.
☐ **Ventilator Care**	☐ **Registered nurse to perform health care procedure(s) required by child.**
☐ **Tracheostomy Care**	☐ **Orientation/training for the registered nurse.**
☐ **Suctioning (Tracheal/Pharyngeal)**	☐ **Coverage by an alternate registered nurse to allow the primary nurse to attend interdisciplinary planning meetings related to the child.**
☐ **Nasogastric tube care and/or feeding**	☐ **Some specialized medical equipment and required maintenance.**
☐ **Complex administration of medication [i.e., via infusion pump, nasogastric tube or injection (other than Auto-injector)]**	☐ **Limited consumable health care items.**
☐ **Central or peripheral venous line intervention**	☐ **Some transportation costs related to medical needs of child.**
☐ **Other clinical interventions requiring judgments and decision making by a medical or nursing professional**	☐ **Auditory intercom system/pager/cell phone.**
	☐ **Other**

Please attach a completed URIS Group B application if necessary.

Family Services and Housing
Education, Citizenship and Youth
Health

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

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 program information (to be completed by the community program)

Type of community program (please √)	
☐ School	Name of community program:
☐ Licensed child care	Contact person:
☐ Respite	Phone: Fax:
☐ Recreation program	Email:
	Address (**location where service is to be delivered**):
	Street:
	City/Town: POSTAL CODE:

Section II - Child information

Last Name **First Name** **Birthdate**

month (print) D D Y Y Y Y

Also Known As

Please check (√) all health care conditions for which the child requires an intervention during attendance at the community program.

☐ **Life-threatening allergy (and child is prescribed an EpiPen)**

Does the child bring an EpiPen to the community program? ☐ YES ☐ NO

☐ **Asthma (administration of medication by inhalation)**

Does the child bring asthma medication (puffer) to the community program? ☐ YES ☐ NO

Can the child take the asthma medication (puffer) on his/her own? ☐ YES ☐ NO

☐ **Seizure disorder**

What type of seizure(s) does the child have? ___

Does the child require administration of rescue medication (e.g., sublingual lorazepam)? ☐ YES ☐ NO

☐ **Diabetes**

What type of diabetes does the child have? ☐ Type 1 ☐ Type 2

Does the child require blood glucose monitoring at the community program? ☐ YES ☐ NO

Does the child require assistance with blood glucose monitoring? ☐ YES ☐ NO

Does the child have low blood sugar emergencies that require a response? ☐ YES ☐ NO

☐ **Cardiac condition** where the child requires a specialized emergency response at the community program.

What type of cardiac condition has the child been diagnosed with? ___

☐ **Bleeding Disorder** (e.g., von Willebrand disease, hemophilia)

What type of bleeding disorder has the child been diagnosed with? ___

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- ❑ **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? ☐ YES ☐ NO
  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? ☐ YES ☐ NO
  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? ☐ YES ☐ NO
  Does the child bring suctioning equipment to the community program? ☐ YES ☐ NO

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______________________________ ______________________
Parent/Legal guardian signature Date

______________________________ ______________ ______________________
Mailing Address Postal Code Phone number