



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 √) <input type="checkbox"/> School <input type="checkbox"/> Licensed child care <input type="checkbox"/> Respite <input type="checkbox"/> Recreation program	Name of community program:	
	Contact person:	
	Phone:	Fax:
	Email:	
	Address (location where service is to be delivered):	
	Street:	POSTAL CODE:
	City/Town:	

Section II - Child information

Last Name	First Name	Birthdate												
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Also Known As

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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.

<input type="checkbox"/> Ventilator Care	<input type="checkbox"/> Registered nurse to perform health care procedure(s) required by child.
<input type="checkbox"/> Tracheostomy Care	<input type="checkbox"/> Orientation/training for the registered nurse.
<input type="checkbox"/> Suctioning (Tracheal/Pharyngeal)	<input type="checkbox"/> Coverage by an alternate registered nurse to allow the primary nurse to attend interdisciplinary planning meetings related to the child.
<input type="checkbox"/> Nasogastric tube care and/or feeding	<input type="checkbox"/> Some specialized medical equipment and required maintenance.
<input type="checkbox"/> Complex administration of medication [i.e., via infusion pump, nasogastric tube or injection (other than Auto-injector)]	<input type="checkbox"/> Limited consumable health care items.
<input type="checkbox"/> Central or peripheral venous line intervention	<input type="checkbox"/> Some transportation costs related to medical needs of child.
<input type="checkbox"/> Other clinical interventions requiring judgments and decision making by a medical or nursing professional	<input type="checkbox"/> Auditory intercom system/pager/cell phone.
	<input type="checkbox"/> 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)

Form with fields for: Type of community program (School, Licensed child care, Respite, Recreation program), Name of community program, Contact person, Phone, Fax, Email, Address (location where service is to be delivered), Street, City/Town, POSTAL CODE.

Section II - Child information

Form with fields for: Last Name, First Name, Birthdate (month, day, year).

Also Known As

Form with a grid for entering 'Also Known As' information.

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

Form with checkboxes for: Life-threatening allergy (and child is prescribed an EpiPen), Asthma (administration of medication by inhalation), Seizure disorder, Diabetes, Cardiac condition, Bleeding Disorder. Each section includes specific questions and YES/NO options.

Family Services and Housing
Education, Citizenship and Youth
Health



<input type="checkbox"/> Steroid Dependence (e.g., congenital adrenal hyperplasia, hypopituitarism, Addison's disease) What type of steroid dependence has the child been diagnosed with? _____	
<input type="checkbox"/> Osteogenesis Imperfecta (brittle bone disease)	
<input type="checkbox"/> Gastrostomy Feeding Care Does the child require gastrostomy tube feeding at the community program? <input type="checkbox"/> YES <input type="checkbox"/> NO Does the child require administration of medication via the gastrostomy tube at the community program? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<input type="checkbox"/> Ostomy Care Does the child require the ostomy pouch to be emptied at the community program? <input type="checkbox"/> YES <input type="checkbox"/> NO Does the child require the established appliance to be changed at the community program? <input type="checkbox"/> YES <input type="checkbox"/> NO Does the child require assistance with ostomy care at the community program? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<input type="checkbox"/> Clean Intermittent Catheterization (IMC) Does the child require assistance with IMC at the community program? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<input type="checkbox"/> Pre-set Oxygen Does the child require pre-set oxygen at the community program? <input type="checkbox"/> YES <input type="checkbox"/> NO Does the child bring oxygen equipment to the community program? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<input type="checkbox"/> Suctioning (oral and/or nasal) Does the child require oral and/or nasal suctioning at the community program? <input type="checkbox"/> YES <input type="checkbox"/> NO Does the child bring suctioning equipment to the community program? <input type="checkbox"/> YES <input type="checkbox"/> NO	

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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.

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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
_____	_____
Mailing Address	Postal Code Phone number