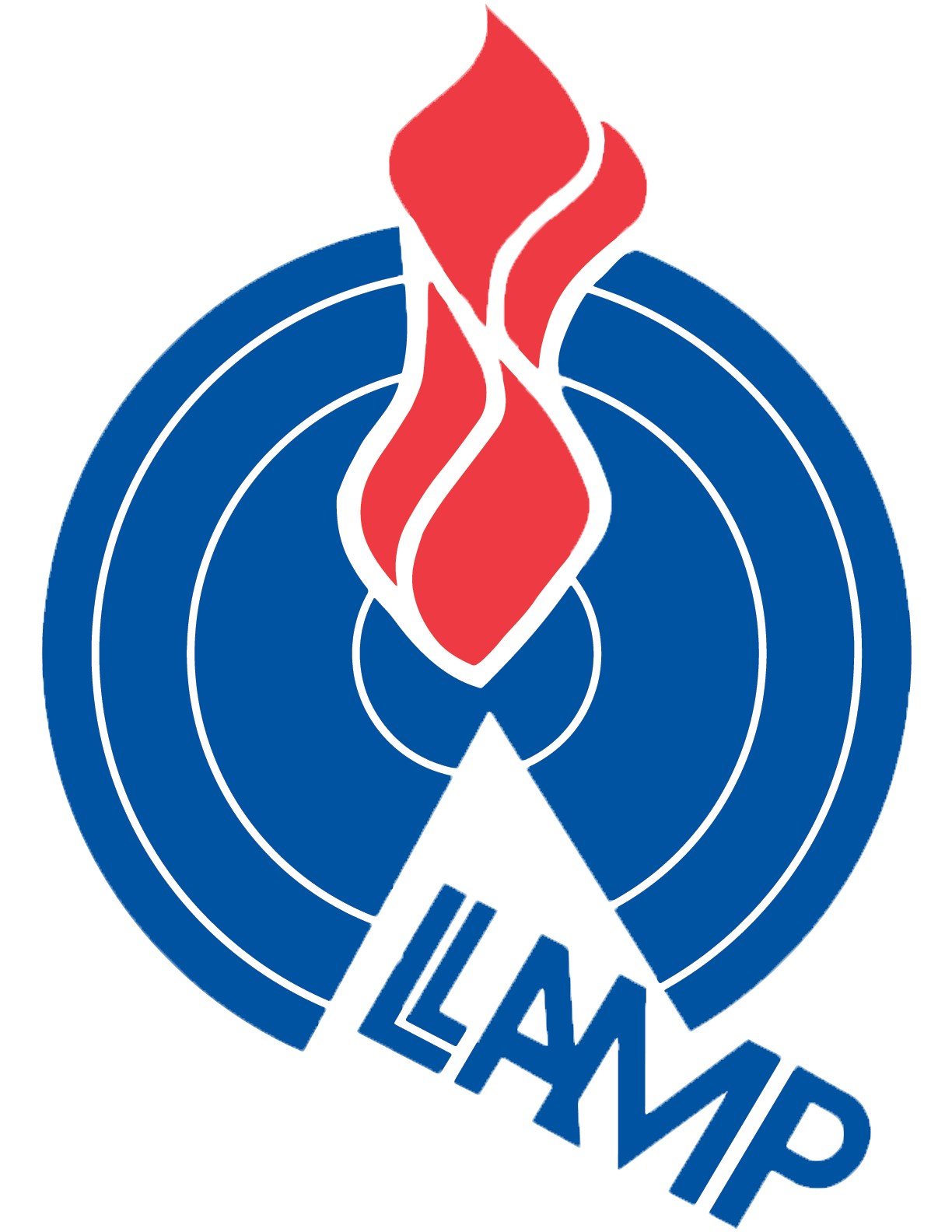
LAMP / East Mississauga CHC

Version: Sept. 2017



**OFFICE USE ONLY**

Client File #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GROUP  DATA **

#### Entered: \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_ /\_\_\_\_\_\_

**Initials:**

**Registration Form and**

Service Agreement

CONFIDENTIAL

PLEASE CLEARLY PRINT YOUR INFORMATION – THANK YOU!

If you have any questions or would like to speak to someone about filling out this form, please ask a staff member.

|  |  |  |  |
| --- | --- | --- | --- |
| Last Name | First Name | | Today’s Date  Day\_\_\_\_\_\_ Month\_\_\_\_ Year\_\_\_ |
| Preferred Name (optional) | Preferred Pronouns (optional) | | Date of Birth  Day\_\_\_\_\_\_ Month\_\_\_\_ Year\_\_\_ |
| Address | | | Postal Code |
| Home Phone # | Work Phone # | | Cell Phone # |
| Emergency Contact:  Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Email (optional) | | | |
| Health Card # \_\_\_\_\_\_ - \_\_\_\_\_\_\_ - \_\_\_\_\_\_\_ Version Code: \_\_\_\_ Expiry Date: Day\_\_\_Month\_\_\_/Year\_\_\_ | | | |
| **Gender Identity:** ❒Female ❒Intersexed ❒Male ❒Trans Female to Male ❒Trans Male to Female  ❒Two-Spirit ❒Other (Please Specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❒ Do not know ❒Prefer not to answer | | | |
| □ **Uninsured**  □ IFH # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | □ Out of Province  Province:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

|  |  |
| --- | --- |
| **LAMP Community Health Centre**  185 Fifth Street, Etobicoke ON, M8V 2Z5  Tel: 416-252-6471 Fax: 416-252-4474 [www.lampchc.org](http://www.lampchc.org/) | **East Mississauga Community Health Centre**  7 – 2555 Dixie Rd., Mississauga ON, L4Y 4C4  Tel: 905-602-4082 Fax: 905-602-5432  www.eastmississaugachc.org |

**Socio-Demographic Information:**

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| **We Ask Because We Care**  We are collecting social information from clients to find out who we serve and what unique needs our clients have. We will also use this information to understand client experiences and outcomes. **ALL INFORMATION COLLECTED IS KEPT STRICTLY CONFIDENTIAL.**  **Do I have to answer all the questions?** - No. The questions are voluntary and you can choose ‘prefer not to answer’ to any or all questions. This will not affect your care.  **Who will see this information?** - This information will be visible only to your health-care team and protected like all your other health information. If used in research, this information will be combined with data from all other clients and no one will be able to identify any of the clients. |

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| **1a. What language would you feel most comfortable speaking in with your health care provider?** Check **ONE** only | | | | |
| 🞎 1. Amharic | 🞎 9. English | 🞎 17. Korean | 🞎 25. Somali | 🞎 33. Urdu |
| 🞎 2. Arabic | 🞎 10. Farsi | 🞎 18. Nepali | 🞎 26. Spanish | 🞎 34. Vietnamese |
| 🞎 3. ASL | 🞎 11. French | 🞎 19. Polish | 🞎 27. Tagalog | 🞎 35. Other  (please specify): |
| 🞎 4. Bengali | 🞎 12. Greek | 🞎 20. Portuguese | 🞎 28. Tamil |
| 🞎 5. Chinese (Cantonese) | 🞎 13. Hindi | 🞎 21. Punjabi | 🞎 29. Tigrinya |
| 🞎 6. Chinese (Mandarin) | 🞎 14. Hungarian | 🞎 22. Russian | 🞎 30. Turkish | 🞎 98. Do not know |
| 🞎 7. Czech | 🞎 15. Italian | 🞎 23. Serbian | 🞎 31. Twi | 🞎 99. Prefer not to answer |
| 🞎 8. Dari | 🞎 16. Karen | 🞎 24. Slovak | 🞎 32. Ukrainian |

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| **1b. If you chose a language above that is not English or French, which of Canada's official languages are you most comfortable with?** Check **ONE** only. |
| 🞎 English  🞎 French |

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| **2. Were you born in Canada?** Check **ONE** only. |
| 🞎 1. Yes 🞎 2. No 🞎 98. Do not know 🞎 99. Prefer not to answer  If **NO**, what country were you born in? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If **NO**, what year did you arrive in Canada? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **3. Do you have any of the following?** Check **ALL** that apply | |
| 🞎 1. Chronic Illness | 🞎 7. Sensory Disability (i.e. hearing or vision loss) |
| 🞎 2. Developmental Disability | 🞎 8. Other (Please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 🞎 3. Drug or Alcohol Dependence | 🞎 9.None |
| 🞎 4. Learning Disability | 🞎 98. Do not know |
| 🞎 5. Mental Illness | 🞎 99. Prefer not to answer |
| 🞎 6. Physical Disability |  |

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| **4. Which of the following best describes your racial or ethnic group?** Check **ONE** only | |
| 🞎 1. Asian - East *(e.g. Chinese, Japanese, Korean)* | 🞎 11. Latin American *(e.g. Argentinean, Chilean)* |
| 🞎 2. Asian - South *(e.g. Indian, Pakistani, Sri Lankan)* | 🞎 12. Métis |
| 🞎 3. Asian - South East *(e.g. Malaysian, Filipino)* | 🞎 13. Middle Eastern *(e.g. Egyptian, Iranian)* |
| 🞎 4. Black - African *(e.g. Ghanaian, Kenyan, Somali)* | 🞎 14. White - European *(e.g. English, Italian, Russian)* |
| 🞎 5. Black - Caribbean *(e.g. Barbadian, Jamaican)* | 🞎 15. White - North American *(e.g. Canadian)* |
| 🞎 6. Black - North American *(e.g. Canadian)* | 🞎 16. Mixed heritage (*e.g. Black - African & White - North American*) Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 🞎 7. First Nations |
| 🞎 8. Indian - Caribbean *(e.g. Guyanese with origins in India)* | 🞎 17. Other(s): Please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 🞎 9. Indigenous/Aboriginal | 🞎 98. Do not know |
| 🞎 10. Inuit | 🞎 99. Prefer not to answer |

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| **5. What is your sexual orientation?** Check **ONE** only if you are **13 years of age or older** | | |
| 🞎 1. Bisexual | 🞎 4. Lesbian | 🞎 7. Other (Please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 🞎 2. Gay | 🞎 5. Queer | 🞎 98. Do not know |
| 🞎 3. Heterosexual | 🞎 6. Two-Spirit | 🞎 99. Prefer not to answer |

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| **6. What was your total family income before taxes last year?** Check **ONE** only | |
| 🞎 1. $0 - $14,999 | 🞎 6. $35,000 - $39,999 |
| 🞎 2. $15,000 - $19,999 | 🞎 7. $40,000 - $59,999 |
| 🞎 3. $20,000 - $24,999 | 🞎 8. $60,000 or more |
| 🞎 4. $25,000 - $29,999 | 🞎 98. Do not know |
| 🞎 5. $30,000 - $34,999 | 🞎 99. Prefer not to answer |
| **How many people does this income support?**  **\_\_\_\_\_\_**# of person(s) 🞎 98. Do not know 🞎 99. Prefer not to answer | |

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| **7. What is your highest level of education completed?** Check **ONE** only | |
| 🞎 1. Pre-school | 🞎 6. None |
| 🞎 2. Primary or equivalent (Grades 1-8) | 🞎 7. Other (Please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 🞎 3. Secondary or equivalent (Grades 9-12/13) | 🞎 98. Do not know |
| 🞎 4. College | 🞎 99. Prefer not to answer |
| 🞎 5. University |  |

**If you are 18 years of age or older, please also answer the following three questions:**

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| **8. How would you describe your sense of belonging to the community?** Check **ONE** only  **(Sense of belonging is feeling like you are part of something, connected and accepted)** | | | |
| 🞎 1.Very strong | 🞎 2.Somewhat strong | 🞎 3.Somewhat weak | 🞎 4.Very weak |

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| **9. In general, would you say your overall physical health is:** | | |
| 🞎 1.Excellent | 🞎 3.Good | 🞎 5.Poor |
| 🞎 2.Very Good | 🞎 4.Fair |  |

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| **10. In general, would you say your overall mental health is:** | | |
| 🞎 1.Excellent | 🞎 3.Good | 🞎 5.Poor |
| 🞎 2.Very Good | 🞎 4.Fair |  |

Please also review LAMP’s code of conduct below and sign the Code of Conduct agreement on page 6.

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| **LAMP/EMCHC CODE OF CONDUCT**  **R espect, cooperation, and understanding.** LAMP/EMCHC celebrates diversity and welcomes everyone.  **E veryone has rights:** to be treated with dignity and respect; to be free from discrimination and harassment; to ask questions; to confidentiality; and to give feedback without fear of consequences.  **S taff, clients, volunteers, and visitors will create a welcoming and safe place for all**. Harassment, discrimination, violence, threats and abusive behavior will not be tolerated or permitted and may result in suspension from LAMP. All complaints are taken seriously and will receive a timely response.  **P lease follow the policies of LAMP.**   * LAMP is a scent free building. * Trading, selling, using, or having alcohol/drugs, or possession of weapons is not permitted on the premises. * Photography/videography is only permitted with obtained consent.   **E xpectations at LAMP include all members holding each other responsible for upholding this code.**  **C onsider that we may be obligated to report to the appropriate authorities under certain circumstances** (see “Uses and Disclosures of PHI” on page 6).  **T hose who wish to help LAMP/EMCHC build a healthy community** are encouraged to participate, take leadership, join LAMP membership, or volunteer. |

LAMP/East Mississauga Community Health Centre Service Agreement

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| PROGRAMS THAT ARE OFFERED: (dependent on site) | | |
| * Adult Drop-In * Adult Learning * Among Friends * ASK! Community Information * Chiropody (Foot) Clinic * Client Advocacy (Notary Public) * Community Development * Counselling | * Dental Care * Diabetes Education * Early Years Centre * Harm Reduction * Health Education * Lesbian, Gay, Bisexual, Transgender, Transsexual, Intersex, Queer, Questioning, 2 Spirit Programs | * Occupational Health * Physiotherapy * Primary Health Care * Seniors Wellness Program * Social Work * Telemedicine * Youth Programs * Nutrition Education |

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| **AS A CLIENT YOU HAVE THE RIGHT TO:** | |
| * Take part in LAMP’s programs and activities. * Know the experience and qualifications of the people serving you. * Receive quality care regardless of your diverse views, culture, spiritual traditions, gender identity, gender expression, sexual orientation and abilities. * Have a clear explanation of the services you will receive and who will provide them. | * Share only the information you want with the people serving you. * Withdraw consent at any time, and refuse any care, services or treatment. * Express concerns and recommend changes without fear of reprisals, interference, or discrimination. * A safe and secure service environment. |

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| **YOUR RIGHTS TO PRIVACY AND CONFIDENTIALITY** |
| This agreement explains your privacy rights and the steps our centre takes to protect your Personal Health Information according to the Personal Health Information Protection Act, 2004 (PHIPA).  The law requires LAMP to store your personal and health information securely. The only people who see it are those involved in your care: staff, volunteers, and students. You also have the right to have some of your personal information stored separately and to access your health record information, in accordance with the legislation.  If you have any questions or concerns about your privacy or confidentiality **please contact LAMP’s Privacy Officer,** the **Director of Clinical Programs** who can be reached at **416-252-9701, ext. 300.** |

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| **COLLECTION OF PERSONAL HEALTH INFORMATION (PHI)** |
| LAMP/EM Community Health Centre is a “***Health Information Custodian***” which means that we store your PHI in our secure electronic record system.  In accordance with the Act, we collect PHI directly from you or from the person acting officially on your behalf. The PHI we collect may include your name, date of birth, Health Card Number, address, health history, records of your visits to LAMP/EM Community Health Centre and the care that you received during those visits.  Occasionally, we collect PHI about you from other sources only if we have obtained your consent or if permitted by law. Other sources include health providers working outside our centre to provide care to you. |

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| **USES AND DISCLOSURES OF PHI** |
| With your consent, we use and disclose your PHI to:   * Communicate with the health care providers in your “Circle of Care.” These are organizations or people responsible for your care (e.g. hospitals, doctors, nurses, nurse practitioners, social workers, etc.); * Assess your eligibility to participate in LAMP/EM Community Health Centre’s programs and services; * Receive payment for your treatment and care (e.g. from agencies that fund services, WSIB, your private insurer or others); * Inform funding agencies such as the Ontario Ministry of Health and Long Term Care and Local Health Integration Networks for health system management purposes; * Guide the planning and management of our programs and services; * Conduct quality improvement activities (e.g. surveys); * Ensure LAMP/EM Community Health Centre complies with legal and regulatory requirements; * Conduct research as approved by a Research Ethics Board; * Fulfil other purposes permitted or required by law (e.g. infectious disease reporting to Public Health).   **We may be obligated by law to disclose information about you if:**   * You indicate that you are a danger to yourself or others. * You tell us that another person may be a danger to you or others. * There is apparent, suspected, or potential abuse. * If someone is in the care of another and are abused or deemed vulnerable. * You report sexual abuse by a regulated health care professional. * The court issues a summons for records or testimony. * You test positive for a communicable disease that we have to report. |

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| **CONSENT FOR THE COLLECTION, USE AND DISCLOSURE OF YOUR PERSONAL HEALTH INFORMATION**  I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have reviewed the LAMP/EM Community Health Centre’s information written above on the collection, use and disclosure of personal health information.  I hereby authorize LAMP/EM Community Health Centre to collect, use and disclose my personal health information (or the personal health information of the client, for whom I am the Substitute Decision-Maker) for the purposes mentioned above.  **Signature of Client (or Substitute Decision-Maker, where applicable):**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Staff Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (I have reviewed the above information with the client or their Substitute Decision-Maker) |

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| **LAMP/EMCHC CODE OF CONDUCT AGREEMENT**  *I have read, understood, and agree to the conditions of membership outlined in LAMP/EMCHC’s* **code of conduct and I have been oriented to LAMP/EM CHC and its services.**  **Signature of Member: Date:**  **Signature of Staff: Date:**  (I have reviewed the Code of Conduct and provided an LAMP/EM CHC orientation with the client or their Substitute Decision-Maker) |