## 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
* 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

**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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Mailing Address Postal Code Phone number