

UNIFIED REFERRAL AND INTAKE SYSTEM (URIS) GROUP B APPLICATION (a)

Section I – To be completed by the community program

Review application, complete and sign in ink — to be completed ANNUALLY.

The purpose of this form is to identify the child's specific health care <u>and</u> if applicable, 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. URIS is a partnership of Health, Education and Family Services. If you have questions about the information requested on this form, you may contact the community program.

Type of community program <i>(please √)</i>		unity Program Name: aurier	Location of Service: ■ Same as on left				
School Licensed child care Respite	Contact	t person: Christine VanHumbeck	Contact person:				
	Phone:	Phone: 204-447-2068					
	Email: c	vanhumbeck@trsd.ca	Email:				
Recreation prog							
Other:	Street a	address: Box 100 Laurier, MB	Street address:				
	City/Tov	wn: R0J1A0	City/Town:				
	Postal (Code:	Postal Code:				
Section II - Child information - to be completed by parent							
Last Name First Name Birthdate							
Month (print) D D Y Y							
Preferred Name (A	lias)	Age Grad	de Gender				
Age Grade Marie (Arias) Age Grade Marie (Arias) M F Other							
		VEC ENG					
Does your child ride the bus? ☐ YES ☐ NO							
	Does your child have any of the following listed health concerns? ☐ YES ☐ NO (check (√) one)						
•	nave anv of th	ne following listed health concei	rns? 🗀 YES 🗀 NO (cneck (V) one) 👚 🛚				
Does your child h	•	-					
Does your child h	•	ne following listed health conceing, please sign here and return this					
Does your child h	answered <u>NC</u>), please sign here and return this	form to the community program.				
Does your child h	answered <u>NC</u>	-	form to the community program.				
Does your child h If you have Parent/ Legal Guardian	answered <u>NC</u>), please sign here and return this	form to the community program. ATURE DATE (MON/DD/YYYY)				
Does your child h ➤ If you have Parent/ Legal Guardian ➤ If you have a	answered <u>NC</u> n NAME answered <u>YES</u>	please sign here and return this Parent/Legal Guardian SIGNA please complete the remainder	form to the community program. ATURE DATE (MON/DD/YYYY) of the form including Section III.				
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Original Effective Date: 2013-Dec Brandon file in Page 1 of 2 Revised Effective Date: 2017-Nov-08 **PMH089** Consults/Referrals: Referrals

			S) Group B Application				
☐ YES	□ NO	Ostomy Care ☐ YES ☐ NO	Does the child have an ostomy/stoma?				
		☐ YES ☐ NO	Does the child require the ostomy pouch to be empti	ad at the community program?			
		☐ YES ☐ NO	Does the child require the established appliance to b				
		☐ YES ☐ NO	·	• • • •			
☐ YES	□ NO	☐ YES ☐ NO Does the child require assistance with ostomy care at the community program? Gastrostomy Care					
LIES			Does the child have a gastrostomy tube? Type of tub	vo.			
		☐ YES ☐ NO	Does the child require gastrostomy tube? Type of the Does the child require gastrostomy tube feeding at the	-			
		☐ YES ☐ NO	Does the child require administration of medication v	• • •			
☐ YES	□ NO	Clean Intermittent Catheterization (CIC)					
C		☐ YES ☐ NO	Does the child require CIC?				
		☐ YES ☐ NO	Does the child require assistance with CIC at the cor	nmunity program?			
☐ YES	□ NO	Pre-set Oxygen		minarity program:			
		☐ YES ☐ NO	Does the child require pre-set oxygen at the commun	nity program?			
		☐ YES ☐ NO	Does the child bring oxygen equipment to the commit				
☐ YES	□ NO	Suctioning (ora		and program.			
	□ N O		Does the child require oral and/or nasal suctioning a	the community program?			
		☐ YES ☐ NO	Does the child bring suctioning equipment to the con	* · · · ·			
☐ YES	□ NO		on where the child requires a specialized em				
L 1E3			- · · · · · · · · · · · · · · · · · · ·	ergency response at tile			
		community program. What type of cardiac condition has the child been diagnosed with?					
☐ YES							
	□ NO	Bleeding Disorder (e.g., von Willebrand disease, hemophilia)					
- VEC		What type of bleeding disorder has the child been diagnosed with?					
☐ YES				idrenai nyperpiasia,			
	hypopituitarism, Addison's disease)						
		What type of steroid dependence has the child been diagnosed with?					
☐ YES		Osteogenesis li	nperfecta (brittle bone disease) What type?				
Section III - Authorization for the Release of Medical Information							
			Information Act (PHIA),I authorize the Community Pro				
			provider serving the community program, all of whom				
supports to my child, to exchange and release medical information specific to the health care interventions identified above and consult with my child's health care provider, 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:							
Child's Name: Child's PHIN:							
			ntake System Provincial Office to include my child's ir				
			ram planning, service coordination and service delive				
			nderstand that my child's personal and personal health m of Information and Protection of Privacy Act (FIPPA				
(PHIA).	accorda	100 1110 1 10 600	in or mornation and recodion or revelop not (1111 P	g and the resonal realin information Ac			
	and that any	other collection use	e or disclosure of personal information or personal he	alth information about my child will not be			
			horized under FIPPA or PHIA.	and information about my office will not be			
•	•		y. I understand that as the parent/legal guardian I ma	y amend or revoke this consent at any			
		quest to the commu		arrierid of revoke this consent at any			
		•	ne information provided on this form, I may contact the	community program directly			
II I IIave a	iny question	is about the use of the	ie information provided on this form, i may contact the	s community program unectry.			
NAME (P	RINT) Pare	nt/ Legal Guardian	SIGNATURE Parent/Legal Guardian	DATE (MMM/DD/YYYY)			
•	•	-	City/Town:				
Work/Daytime Phone:		:	Cell Phone:	Home Phone:			

Original Effective Date: 2013-Dec Revised Effective Date: 2017-Nov-08

Brandon file in Consults/Referrals: Referrals