TrueMedica

# PATIENTS

## Enrolment Form

### Meet Dr. Brenda Igbeyi

We are excited to welcome Dr. Igbeyi to our team at TrueMedica Clinic! To become a patient, please **complete** this form, **print** it, and **submit** it in person or via email at physicianstruemedica@gmail.com

Please note, enrolment is not guaranteed. It is based on a first-come, first-served basis, and applications will be reviewed on an ongoing basis. Once enrolment is finalized, we will be hosting a meet and greet with Dr. Brenda Igbeyi to give you the opportunity to get to know her.

We look forward to welcoming you to the TrueMedica family!

**OPTIONAL**

**FORM TO SWITCH PHARMACIES - DO NOT FILL THIS FORM OUT IF YOU DO NOT WANT TO SWTICH YOUR PHARMACY**

**Truemedica Health Pharmacy**
411 Bayfield Street, Unit B12,
Barrie, Ontario L4M6E5
Tel: (705)503-8783 Fax: (705) 503-0122

Date: / /

Previous Pharmacy Name: .....

Previous Pharmacy Tel: .....

Previous Pharmacy Fax: .....

I, the undersigned, consent to the transfer of my medications from the previous pharmacy to **Truemedica Health Pharmacy**.

Patient's Name:

Phone Number:

Birthday: / /

Signature: ----------

**Re: Request for transfer of Whole Profile / Partial Profile**

We would appreciate receipt of the following pharmacy profile for the patient undersigning.

Kindly, transfer all remaining refills and a copy of medications with zero remaining refills.

Please, send a copy of insurance billing information and original hardcopies for all logged prescriptions.

Regards,

**Pharmacist: Sherif Girgis (OCP: 604704)**

# NEW PATIENT INTAKE FORM

FIRST NAME: _____ PREVIOUS FAMILY PHYSICIAN: _____
LAST NAME: _____ DOB: _____ CARE CARD: _____
CONTACT TEL: _____ E-MAIL: _____
ADDRESS: _____
CITY: _____ POSTAL CODE: _____ COUNTRY: _____

**EMERGENCY CONTACT INFO:**
Relation _____ Contact number: _____
Relation _____ Contact number: _____

Is it OK to contact you by e-mail? ☐Yes ☐No

**PAST MEDICALHISTORY**:

_____
_____
_____
_____

**PAST SURGERIES AND PROCEDURES**:
(please include dates)

_____
_____
_____

**FAMILY HISTORY:** please indicate any significant medical issues among family members and who they affect
(e.g. Diabetes, Cancer, High blood pressure, heart attack, stroke, lung disease, etc)

_____
_____

**PREVENTATIVE HEALTH/LIFESTYLE:**
(please circle one)
Do you smoke? ☐Yes ☐No
Do you use any recreational drugs? ☐Yes ☐No
Do you exercise regularly? ☐Yes ☐No
If yes, describe: _____

Do you drink alcohol? ☐Socially ☐Regular ☐Never
Family dependents: _____

**EDUCATION/OCCUPATION:** _____
**HOBBIES/INTERESTS:** _____

**PRESCRIPTION MEDICATIONS:**

_____
_____
_____

**NON-PRESCRIPTION MEDICINES:**
(Over- the-counter, herbal, vitamins, other etc)

_____
_____
_____

**ALLERGIES:**
_____ Reaction: _____ _____ Reaction: _____
_____ Reaction: _____ _____ Reaction: _____

**When did you last have the following;**

- Pap Smear _____
- Mammogram _____
- Hemoccult- FIT _____
  (stool test for colon cancer screen)
- Colonoscopy _____
- Prostate Exam _____
- Complete Physical _____
- Flu Shot _____
- Pneumonia _____
- Tetanus _____
- HPV _____
- Shingles _____
- Hepatitis A _____
- Hepatitis B _____
- Other _____

Ontario

Ministry of Health

Clear Form

# Primary Health Care New Patient Declaration

***Do not mail this form to the ministry. This form must remain in the physician's office for audit purposes.***

Please complete this form if you are a new patient of a primary care physician and have signed a Patient Enrolment and Consent to Release Personal Health Information form. If you are signing on behalf of a child or dependent adult, and have completed a Patient Enrolment and Consent to Release Personal Health Information form on their behalf, complete the applicable sections below.

## Declaration

**I am signing on behalf of *(check the applicable boxes)***

- ☐ myself *(complete sections A and C)*
- ☐ the children listed below of whom I am the parent or guardian *(complete sections B and C)*
- ☐ the dependent adult (s) listed below for whom I have a power of attorney for personal care *(complete sections B and C)*

**I hereby declare that the patient(s) named below does/do not have a family physician due to one or more of the following circumstances: *(check applicable boxes)***

- ☐ The patient's family physician has moved to another community.
- ☐ The patient has moved to another community.
- ☐ The patient's physician is no longer available due to illness/death/retirement.
- ☐ The patient's physician is no longer available due to change of practice type.
- ☐ Up until now the patient has not had, or felt the need for a family physician.

## Section A: Patient Information

| First Name | Last Name | Health Number |
|---|---|---|
| | | |

## Section B: Children and Dependent Adults

| | First Name | Last Name | Health Number |
|---|---|---|---|
| 1. | | | |
| 2. | | | |

*For additional children / dependent adults, please complete another New Patient Declaration form.*

## Section C: Signature and Date

| Signature | Date yyyy/mm/dd |
|---|---|
| | |

## Section D: Physician Signature and Date

I declare that the above patient is not presently a patient of mine or, to the best of my knowledge, of any other physician in the primary care group with which I am affiliated (if applicable). I also declare that no child listed (if any) is a newborn of any existing enrolled or non-enrolled patient of mine, or to the best of my knowledge, of any other physician in the primary care group with which I am affiliated (if applicable).

I agree to accept the above-noted patient(s) into my practice and to provide ongoing health care to the patient(s) from the date of this document. I will keep this document available on file in my primary office location and will provide copies to the Ministry of Health as required for verification purposes.

| Physician Last Name *(print)* | First Name *(print)* |
|---|---|
| | |

| Physician Signature | Date yyyy/mm/dd |
|---|---|
| | |



4367-84 (2022/12)

Print Form

Ontario

Ministry of Health
and Long-Term Care

Microfilm use only

# Patient Enrolment and Consent to Release Personal Health Information

*Please PRINT using black or blue ballpoint pen.*

Collection of the information on this form is under the authority of the *Ministry of Health Act*, subsection 6(1) and (2) and the *Health Insurance Act*, R.S.O. 1990, c. H.6, s.4(2)(b) and (i), 4.1(1) and (2), 10 and 11(1). For information about collection practices, contact the Director, Registration and Claims Branch, Box 48, 49 Place d'Armes, Kingston ON K7L 5J3, INFOline tel. 1 888 218-9929 or by mail through the addresses listed for local Ministry of Health and Long-Term Care offices.

## Section 1 – I want to enrol myself with the family doctor identified in Section 4

Last Name | First Name | Second Name

Health Number | Version Code

Date of Birth *(yyyy/mm/dd)* | Sex ☐ M ☐ F

Send notices from my family doctor's office to me by:
☐ regular mail ☐ email *(if possible)*

Email Address:

**Mailing Address ▶** Apartment # | Street No. and Name or P.O. Box, Rural Route, General Delivery

City/Town | Postal Code

**Residence Address ▶** Apartment # | Street No. and Name or Lot, Concession and Township

City/Town | Postal Code

or ☐ same as mailing address

## Section 2 – I want to enrol my child(ren) under 16 and/or dependent adult(s) with the family doctor identified in Section 4

**A**

Last Name | First Name | Second Name

Health Number | Version Code

Date of Birth *(yyyy/mm/dd)* | Sex ☐ M ☐ F

I am this person's
☐ parent
☐ legal guardian
☐ attorney for personal care

**Mailing Address ▶** Apartment # | Street No. and Name or P.O. Box, Rural Route, General Delivery

City/Town | Postal Code

or ☐ same as Section 1

**Residence Address ▶** Apartment # | Street No. and Name or Lot, Concession and Township

City/Town | Postal Code

or ☐ same as Section 1

**B**

Last Name | First Name | Second Name

Health Number | Version Code

Date of Birth *(yyyy/mm/dd)* | Sex ☐ M ☐ F

I am this person's
☐ parent
☐ legal guardian
☐ attorney for personal care

**Mailing Address ▶** Apartment # | Street No. and Name or P.O. Box, Rural Route, General Delivery

City/Town | Postal Code

or ☐ same as Section 1

**Residence Address ▶** Apartment # | Street No. and Name or Lot, Concession and Township

City/Town | Postal Code

or ☐ same as Section 1

## Section 3 – Signature

I have read and agree to the Patient Commitment, the Consent to Release Personal Health Information and the Cancellation Conditions on the back of this form. I acknowledge that this Enrolment is not intended to be a legally binding contract and is not intended to give rise to any new legal obligations between my family doctor and me.

I am signing on behalf of *(check all that apply)*
☐ myself ☐ child(ren) ☐ dependent adult(s)

My Name
last name | first name

Signature
X

Date *(yyyy/mm/dd)*

Home Telephone No.
( )

Work Telephone No.
( )

## Section 4 – Family doctor information

PG07799

(Include Billing no. and Group no.)

Family Doctor's Signature
X

Date *(yyyy/mm/dd)*





**PHYSICIAN COPY**

# Patient Enrolment and Consent to Release Personal Health Information

**Patient Commitment**

I agree to contact my family doctor, (or if applicable the group to which my family doctor belongs or the designated Telephone Health Advisory Service if available to me), when I, or my enrolled child(ren) or dependent adult(s), need primary care medical advice or treatment. I promise to do this unless there is an emergency or I am travelling away from home.

I agree that if I or the person(s) I have signed for move, I will contact my family doctor's office or the ministry (see box below) with a new address and telephone number.

I understand that I can end my enrolment with this family doctor and enrol with another family doctor after six weeks have passed from the date that I complete and sign this form (immediately if I have moved). However, I agree not to change the doctor with whom I am enrolled more than twice a year.

I understand that by enrolling a child under 16 or a dependent adult, my signature on the front of this form means that I agree to these terms and conditions on behalf of that person. When an enrolled child reaches 16 years of age, the ministry will contact him or her to confirm enrolment/consent with the family doctor.

**Consent to Release Personal Health Information**

I understand that my family doctor will be able to offer better medical care if I permit my family doctor and the ministry to share appropriate and relevant information relating to my health.

I agree to allow my family doctor, other family doctors in the Patient Enrolment Model (if applicable) and the ministry to exchange the information in this form related to my enrolment.

I agree that my family doctor and the ministry can exchange information about my name, address and telephone number.

I agree to allow the ministry to release the following specific information to my family doctor:

- dates of immunizations (flu shots, etc.)
- dates of preventive care screening services (pap tests, mammograms, etc.)
- dates of service, fees paid and fee codes of primary health care services provided to me by a family doctor outside my family doctor's Patient Enrolment Model (if applicable).

If the Telephone Health Advisory Service is available to me, I agree to allow my family doctor and the ministry to exchange only the following information with the designated Telephone Health Advisory Service: my name, health number and version code, address, date of birth, gender.

I understand that this consent to release personal health information ends when:

- My enrolment with my family doctor ends or
- I cancel my consent by writing or telephoning the Ministry of Health and Long-Term Care (see box below).

The ministry will inform my family doctor when the consent is no longer valid. However, I understand that the information already released to my family doctor will remain in my medical file.

**Cancellation Conditions**

Enrolment with my family doctor and my consent to release personal health information will end when:

a) I cancel my enrolment by writing my family doctor or by writing or telephoning the ministry *(see box below);*
b) I no longer qualify for health care services under the *Health Insurance Act (Ontario);*
c) the Patient Enrolment Model to which my doctor belongs no longer exists;
d) my family doctor chooses to discontinue acting as my family doctor in accordance with the College of Physicians and Surgeons of Ontario guidelines;
e) I enrol with another family doctor; or
f) the ministry grants me an extended absence.

My enrolment with my family doctor and my consent to release personal health information may end when:

a) I consistently fail to meet the obligations to which I agreed in the Patient Commitment *(above);*
b) my family doctor leaves this Patient Enrolment Model;
c) I become a resident of a long-term care facility;
d) I am imprisoned in a provincial or federal correctional institution; or
e) I move outside the geographic area where the Patient Enrolment Model to which my family doctor belongs regularly provides services.

**Contact Information:**

Ministry of Health and Long-Term Care
P.O. Box 48, Station Main
Kingston ON K7L 9Z9

Call: INFOline 1 888 218–9929
TTY 1 800 387–5559

***(Cette formule est aussi disponible en format bilingue. Pour recevoir une copie, composez : 1 888 218–9929)***

4383–80 (2006/04)

# Patient Agreement For Long-Term Opioid Therapy

This agreement is based on the ***"Recommendations of the Canadian Guidelines for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain"***, which has been adopted by the College of Physicians and Surgeons of PEI. Chronic pain is pain that lasts for more than 6 months or pain that lasts longer than expected after an injury or illness.

1. **I** _____, ***agree*** that Dr. _____ will be the only physician prescribing opioid, also known as narcotic, pain medication for me and ***I agree*** that I will obtain all of my prescriptions for opioid(s) (and any other psychoactive medications) at one pharmacy location. The only exception to this will be in an emergency or the unlikely event that I run out of medication and ***I agree*** to inform any other treating physician of this agreement. ***I further agree*** to inform my physician as soon as possible should such occasion occur and to inform my physician if I am admitted to hospital. ☐

2. ***I understand*** that the use of any mood-altering substance, such as tranquilizers, sleeping pills, alcohol or illicit drugs (like cannabis, cocaine, heroin or hallucinogens) can cause adverse effects or interfere with opioid therapy. ***I agree*** to refrain from using any of these substances without the prior agreement of my physician. ☐

3. ***I agree*** not to accept any opioid medication from any other person. ***I agree*** not to use any over the counter opioid medication, such as 222's or Tylenol#1s. ***I agree*** to check with my physician or pharmacist before taking any other over the counter medication or herb. ☐

4. ***I agree*** to take my opioid medication at the dose and frequency prescribed by my physician. I will not request earlier prescription refills. ***I agree*** not to increase the dose without first discussing it with my physician. ***I agree*** to not disrespect or harass my physician or clinic staff regarding my prescription refills. Running out of medication early, requesting early refills, escalating doses without permission and losing prescriptions could be signs of misuse of my medication and may lead my physician to discontinue my opioid therapy. ☐

5. ***I agree*** to attend all reasonable appointments, treatments and consultations as requested by my physician. ***I agree*** to participate in other chronic pain treatment modalities recommended by my physician. Chronic opioid therapy is only one part of my overall pain management plan. ☐

6. ***I agree*** to have office visits (at least every 3 months) with my physician to review my opioid therapy. ***I agree*** to bring all my unused opioid medication(s) in their original pharmacy bottles to all appointments. ***I agree*** to random, unscheduled pill counts and urine testing. The presence of non prescribed drug(s) in the urine may result in discontinuation of my opioid treatment. ☐

7. ***I agree*** to set specific, functional treatment goals, e.g., improving my ability to do things I did prior to the onset of my pain. I am aware this opioid medication will not completely eliminate my pain, but is intended to reduce it enough that I may become more functional (physically and psychologically) at home and at work, and improve my quality of life. My physician and I will continually evaluate the effect of all treatments on achieving my treatment goals. Persistent functional decline while taking opioid medication may result in re-evaluation of my opioid treatment plan. ☐

8. ***I understand*** that some of the common side effects of opioid therapy include impaired thinking, drowsiness, dizziness, impaired motor ability, nausea, vomiting, constipation, sexual dysfunction, abnormal sleep, edema, sweating and itchiness of the skin. Because drowsiness may occur when starting therapy or when increasing dosage, ***I agree to refrain from driving*** any motorized vehicle or operating dangerous machinery until drowsiness disappears and my physician agrees I am fit to drive again. Failure to comply with this advice may result in a physician's duty to report to the provincial Ministry of Transportation. Side effects can be minimized by slowly increasing the dose and by using anti-nausea drugs, stool softeners and bowel stimulants. ☐

9. ***I agree*** to be responsible for the secure storage of my opioid medication at all times, in particular to keep safe from children. ***I agree*** not to sell, lend or in any way give my prescribed opioid medication to any other person. It is illegal and could harm them. Lost, stolen or damaged opioid may not be replaced until the next ☐

regular renewal date. If my opioid medication is stolen, I will report this to police and my physician and ***I agree*** to produce a police report of this event if requested to do so.

10. ***I agree*** to use appropriate measures to prevent pregnancy during my opioid treatment and ***I certify*** that I am not pregnant at this time; because I understand if I become pregnant while taking opioids, my child will be physically dependent to the opioid and withdrawal can be life threatening for a baby. ☐

11. ***I understand*** that in an emergency situation, it is important for emergency personnel to know I am taking opioid medication and it is strongly recommended that I wear a medical alert bracelet or necklace which notes I take opioid medication. ☐

12. ***I understand*** that accidental opioid overdose is uncommon, but can be dangerous when starting or increasing the dose. Some symptoms of overdose may include impaired thinking, slurred speech, becoming upset or crying easily, poor balance, drowsiness and slowed breathing (this could result in brain damage, trauma and death). If I develop these symptoms ***I agree*** to go to the Emergency Room. ☐

13. ***I understand*** that I may develop tolerance to the opioid medication that I am prescribed. Tolerance means a state of adaption in which exposure to the drug induces changes that result in diminution of one or more of the drug's effects over time. The dose of opioid may have to be titrated up or down or the prescribed opioid changed to a different one, in order to achieve maximum function and a realistic decrease of my pain. ☐

14. ***I understand*** that using long-term opioids to treat chronic pain may result in the development of a physical dependence on this medication and that sudden decreases or discontinuation of the medication will lead to symptoms of opioid withdrawal (such as runny nose, yawning, large pupils, nausea, vomiting, abdominal pain, cramps, diarrhea, aches, sweats, chills, goosebumps, altered mood, irritability) that may occur 24-48 hours after the last dose. This is a normal physiological response and though uncomfortable, it is not life threatening. ☐

15. ***I understand*** that there is a risk that I may become addicted to the prescribed opioid medication. Those at greatest risk have a personal or family history of addiction (e.g. alcohol or other drugs). ***I agree*** to inform my physician of such a history. A history of addiction does not, in most cases, disqualify me from opioid treatment for pain. Should a concern about addiction arise during my treatment, my opioid medication may need to be discontinued and I may be referred an addiction specialist. ☐

16. By signing this agreement, ***I give my physician consent*** to contact any other physician, health care provider, pharmacy, family member, legal authority or regulatory agency to obtain or provide information related to my pain management or any alleged misuse of my medications. ***I agree*** to a family, friend or significant other meeting if my physician feels it is necessary. ***I agree*** to have my medical records include information about this contract so that other physicians may be informed if necessary. ☐

*I have read this agreement, understand it and have had all my questions answered satisfactorily.* ***I consent to the use of opioid medication under the terms outlined in this agreement.*** *I accept full responsibility for any and all risks associated with the use of opioid therapy.* ***I understand*** *that if I break this agreement, Dr._____ may choose to cease writing opioid prescriptions for me. Withdrawal from the medication will be coordinated by my physician and may require specialist referral. In addition, my physician may choose to cease being my family physician.*

_____
Date

_____ _____
Patient Name *(please print)* Physician Name *(please print)*

_____ _____
Patient Signature Physician Signature

Ontario Health atHome

# E-Mail Consent and Use

***PLEASE PRINT***

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Email offers an easy and convenient way for our patients, their Substitute Decision Makers (SDM) or those appointed with Powers of Attorney (POA) to communicate with their Care Coordinator and Ontario Health atHome. We believe that the ease of communication Email affords is a benefit to patients and to Ontario Health atHome. In many circumstances, it has advantages over telephone calls or postal services. However, there are a number of risks associated with sharing information via electronic mail, noted below:

- *There is no guarantee that the recipient has received the Email message. Email messages are not forwarded during an employee's absence. To guarantee important or urgent messages are received and followed up, please communicate through another means, such as telephone.*
- *Ontario Health atHome does not guarantee the security of electronic information systems external to tOntario Health atHome. Electronic data can be forwarded, printed, saved and stored in systems located outside provincial or federal jurisdictions. To ensure confidentiality, it is strongly advised that you use another form of communication for sensitive information.*

**Please review carefully these policies and procedures for contacting Ontario Health atHome using Email:**

- *Email communication must be approved by the patient or their authorized substitute decision maker, and the Email Consent Form must be signed and returned to Ontario Health atHome for retention in the patient file, for each person who wishes to communicate via email.*
- *Email messages should be concise and contain minimal identifying personal health information.*
- *Do not communicate urgent or emergency situations or requests through Email.*
- *Notify Ontario Health atHome immediately when/if your Email address changes*

I wish to communicate with Ontario Health atHome via Email and permit them to use Email to communicate with me. I understand and accept the risks in using Email for communicating patient personal health information. I understand that my Email address will become part of the patient health record and may be shared with health care partners or authorized third parties.

I also understand and accept that Ontario Health atHome cannot guarantee the security of systems external to Ontario Health atHome through which my Email messages may be transmitted. I understand and agree the content of all Email messages will be summarized and/or copied, and added to the patient's permanent medical record. I may change or revoke this permission to use the Email system for communication at any time by contacting the Ontario Health atHome Care Coordinator.

Name of Requestor: _____ Relationship to Patient: _____
*(person requesting to communicate with Ontario Health atHome via email)*

Signature of Requestor: _____ Date:

Email Address : _____

Signature of Patient (or authorized Substitute Decision Maker): _____

Date: _____