InspireHealth
Supportive Cancer Care

Patient Intake Form

"*" Indicates required field

Please return all completed pages to:
#200 – 1330 W. 8th Ave
Vancouver, BC
V6H 4A6
Fax: 604 734 7105
info@inspirehealth.ca

Patient Information

Full Name *

First Name

Last Name

What do you prefer to be called

(if different from above)

Pronoun

Primary phone *

E-mail *

Personal Health/Care Card Number

Date of Birth *

Emergency/Support Person Contact Information

Emergency Contact Information

Full Name *

Relationship

Primary Phone *

Personal Health History

Please briefly describe any significant personal health history (e.g.: heart disease, osteoporosis, anxiety, etc.):

List your current medications, including supplements and herbal remedies:

Medication Name	Dose	Reason Used
Medication Name	Dose	Reason Used
Medication Name	Dose	Reason Used

Please describe any substance intake and approximate frequency (e.g.: alcohol, tobacco, cannabis, etc).

Have you recently had any significant fluctuations in weight and/or appetite?
If yes, please describe:

Cancer Care Information

Cancer Diagnosis or Genetic Risk *	**Stage (if known)**	**Date of Diagnosis**

Are you currently receiving cancer treatment? *

Yes

No

Where do/did you go for your cancer care? (e.g. BC Cancer in Victoria, Lions Gate Hospital, etc.): *

Please briefly describe any past or present cancer treatments and include approximate dates (e.g.: chemotherapy, radiation, surgery):

Do you have any cancer metastases ('mets' or spread of cancer)?
If yes, please indicate where:

Individual Appointments

Complete as applicable.

What are you hoping for from your appointment with a Registered Dietitian?

What are you hoping for from your appointment with a Clinical Counsellor?

What are you hoping for from your appointment with an Exercise Therapist?

What are you hoping for from your appointment with a Supportive Care Physician?

Consent

Patients of InspireHealth requesting services have the right to Informed Consent; that is, your full and active participation in decisions which affect you and your freedom of choice based on the information shared. InspireHealth respects your right to ongoing informed consent at the outset of the therapeutic relationship and throughout your care. You have the right to withdraw consent at any time and terminate services. When it comes to the direction and goals of your therapy, you are the primary decision maker. You have the right to accept or reject any task, exercise, or practice suggested by your clinician, and to be informed of the risks, benefits, rationale, alternatives, and interpretations of all suggested interventions.

1. **CONSENT TO HAVE MY CASE DISCUSSED WITH OTHER MEMBERS OF THE INSPIREHEALTH TEAM**

   **I acknowledge that I understand InspireHealth works as a multi-disciplinary team. I know I can review this document with an InspireHealth clinician at any time.
   By checking this box, I consent to proceed with receiving care from InspireHealth.**

InspireHealth's multidisciplinary team works as one unit of confidentiality and care. Only the clinicians (e.g. Physicians, Counsellors, Registered Dietitians, and/or Exercise Therapists) you are seeing at InspireHealth will have access to your file. InspireHealth's clinicians work collaboratively to ensure optimal supportive care for patients and support people. InspireHealth recognizes confidentiality, respect, and trust are of prime importance in the healing relationship. We ensure any care collaboration and communication is done with utmost respect and ethical consideration of the patient.

2. LIMITS OF CONFIDENTIALITY

I acknowledge that I have read and understand InspireHealth's limits of confidentiality and consent to receive care from InspireHealth's clinical team.

Confidentiality is an essential part of the InspireHealth healing environment; your privacy is important to us. Your healthcare information belongs to you and is held in confidence by InspireHealth except in the case of the following circumstances:

1. If the information is required by law to be disclosed (e.g., child or vulnerable person in need of protection, court order, subpoenaed).
2. If staff believe there may be a significant risk of harm to you or others.
3. When informed and voluntary consent is provided by you to release information.

PATIENT RECORDS
Summarized information from appointments with clinicians will be charted in a secure electronic medical records system, which is encrypted and only accessible by InspireHealth clinical staff. Family members and support people will have a separate secure record in our system. Any paper documents will be kept in a locked and secure location. Emails may be used with your permission to provide details on resources you require. Please note that email content may become part of your InspireHealth chart.

GROUP CONFIDENTIALITY
When participating in a group setting, the InspireHealth clinician assures that they are connecting from a secure and private setting to hold the groups. Confidentiality for groups may be limited on the end of the group participants. To ensure confidentiality of the group, we ask all participants to connect from a secure and confidential space where conversation cannot be overheard by others. However, the clinician cannot assure the environment of the other group participants and therefore it is each participant’s responsibility to assure they are in a private and secure setting for their group experience. InspireHealth can therefore not take responsibility for the confidentiality being upheld by other group participants.

3. CONSENT TO PARTICIPATE IN TELEMEDICINE CONSULTATION

I acknowledge that I have read and understand the provisions in this form and consent to participation in telemedicine consultations.
This form is intended to obtain your permission to participate in telemedicine consultations with InspireHealth health professionals.

Telemedicine is the use of telephone and/or video conference by our healthcare providers to provide clinical group programming, and individual care consultations. Telemedicine allows InspireHealth to provide services to you that may otherwise require you to travel long distances. Your participation in any telemedicine consultation is completely voluntary.

By signing this form, you are acknowledging that you understand the following:
1. You may choose to have your consultation by telephone or video call.
2. InspireHealth will not keep video and/or audio recordings of the session but will keep an electronic written medical record.
3. Video calls are enabled through TELUS Business Connect and Zoom, which are both PIPEDA and PHIPA compliant. On behalf of InspireHealth, TELUS Business Connect and Zoom collect certain personal information only to set up your user account, provide you with access to the system and administer your account. InspireHealth is responsible for securely storing your personal information. For full details of TELUS Business Connect's privacy policy visit: www.telus.com/privacy. For full details of Zoom's privacy policy visit: https://zoom.us/privacy/

Confidentiality for telemedicine or telephone sessions may be limited on the end of the patient. The InspireHealth clinician assures that they are providing support from a secure and private setting, but they cannot be responsible for confidentiality on the patient's end of the conversation. It is the patient's responsibility to assure they are in a private and secure setting for their consultations.

4. CONSENT TO HAVE MY CASE DISCUSSED WITH MY PRIMARY CARE PROVIDER, ALLIED HEALTH PROVIDERS AND/OR SPECIALIST

I give permission to the clinicians I see at InspireHealth to discuss aspects of my care with other health care providers when necessary.

It may benefit your care for InspireHealth's clinicians to consult on aspects of your case with your other health care provider(s). Your InspireHealth clinician will discuss this option and request your permission prior to any discussion with your other health care providers.

5. CONSENT TO THE RELEASE OF MEDICAL INFORMATION FROM BC CANCER, ONCOLOGISTS OR OTHER SPECIALISTS

I authorize BC Cancer, oncologists, or other specialists to release my medical information to InspireHealth

E-Signature*

First Name Last Name

Date *