BCITS technology for living

PROVINCIAL RESPIRATORY OUTREACH PROGRAM

MANDATORY CLIENT INFORMATION AND RELEASE FORM (PLEASE PRINT)

PERSONAL INFORMATION

Name of Applicant:_____

(First) (Last)

Date of Birth:_____ Sex: M: ☐ F: ☐ Date of Application:_____

M/D/Y M/D/Y

Name of Current Care Residence (if applicable):_____

Street Address:_____

City:_____Postal Code:_____

Phone: _____(ext)_____Fax:_____Email:_____

Home Address if different from above:

Street Address: _____

City:_____Postal Code:_____

Phone:_____(ext)_____Fax:_____ Email:_____

CONTACT PERSONS

(i.e., A person who will assume responsibility for completion of forms, arranging appointments, etc. if client is unable to do this.)

Primary Contact:

Name:_____Relationship to client:_____

Street Address:_____

City:_____Postal Code:_____

Phone:_____(ext)_____Fax:_____Email:_____

Alternate Contact:

Name:_____Relationship to client: _____

Street Address:_____

City:_____Postal Code: _____

Phone:_____(ext)_____Fax:_____ Email: _____

Form Completed by:

Client: Yes ☐ No ☐ Primary Contact: Yes ☐ No ☐ Alternate Contact: Yes ☐ No ☐

If none of the above:

Name: _____Relationship to client: _____

Street Address: _____

City: _____Postal Code: _____

Phone: _____(ext)_____Fax:_____Email:_____

PHYSICIAN INFORMATION

Referring Respirologist/Physician: _____

Phone:_____(ext)_____Fax: _____

Facility: _____Phone:_____(ext) Fax:_____

Address:_____

_____Postal Code: _____

Family Physician: _____

Phone: _____(ext)___Fax: _____

Address: _____

_____

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1PROVINCIAL RESPIRATORY OUTREACH PROGRAM
AUTHORIZATION TO ACCESS AND DISCLOSE INFORMATION

The BC Association for Individualized Technology and Supports for People with Disabilities (BCITS) works co-operatively with other agencies on behalf of the client and in the best interest of the client. In order to work effectively with these agencies, the BCITS representative will on occasion need to correspond, either in written or verbal form, with that agency only as it relates to the individuals' respiratory care.

I,_____, hereby authorize the BCITS and/or its representatives to release or obtain from such agencies, individuals, medical centres or hospitals as are concerned with my care, any and all pertinent information which may be necessary to assist in providing me with respiratory related services.

I also consent to:

☐ Visits by a BCITS representative (ie. Respiratory Therapist)

☐ A BCITS representative attending meetings, specifically regarding my care and/ or discharge planning

☐ A BCITS representative acting as a community resource

☐ Would like to be contacted by Peer Support Group

☐ Would not like to be contacted by Peer Support Group

I have been informed of all the reasonably foreseeable disclosures of information, including to third party payers such as insurance companies, and understand and agree that these disclosures are made by BCITS with my permission. When such disclosures are in writing, I will be sent a copy. This release is in effect only as long as my file remains open and active with the BCITS.

Any personal information received by The BC Association for Individualized Technology and Supports for People with Disabilities is protected under the BCITS Personal and Business Conduct Policy (1996) and the Freedom of Information and Protection Privacy Act.

SIGNATURE: _____ DATED THIS _____ DAY OF _____ 20____

CLIENT FIRST NAME:_____ LAST NAME: _____

THE FOLLOWING TO BE COMPLETED BY WITNESS IF ABOVE SIGNED WITH AN "X" OR BY CLIENT REPRESENTATIVE IF CONSENT IS MADE ON CLIENT'S BEHALF:

FIRST NAME:_____ LAST NAME: _____ PHONE : _____

SIGNATURE: _____ RELATIONSHIP TO CLIENT: _____DATE:_____