THE Access Point NORTHWEST

710 Victoria Ave. E, Thunder Bay, ON, P7E 5P7
Phone: (807) 624-3400
Fax: (807) 624-3525

Application Form

Privacy Policy

Purpose for Collection and Use of Personal Health Information (PHI)

We collect, use, and disclose PHI only for the purposes of identifying the appropriate service needs as well as:

- Collecting relevant information contained in the records maintained by the organizations associated with The Access Point Northwest.
- Making referrals to the associated agencies for services, and to fulfill other purposes required or permitted by law.
- Sending this application to any agencies that will be providing services.
- Disclosing the PHI to a person or organization other than those associated without consent in limited circumstances required by law, such as emergencies of child welfare concerns.
- Use of de-identified PHI about applicants to plan and deliver services, for program evaluation, for statistical purposes, and for reporting to our funders.

Privacy Officer

If there are any questions or concerns about privacy, please contact our Privacy Officer with The Access Point Northwest at (807)-683-8200. If there are still concerns, please contact the Office of the Information and Privacy Commissioner at 1400-2 Bloor St E, Toronto, ON M4W 1A8, (416) 326-3333.

Referral Process

Please fill out all included pages. To withdraw the application, please contact (807) 624-3482.

The following referrals can only be completed by the primary care provider: _____
(Billing or College Number)

☐ **Chronic Pain Management**

Declaration and Consent

☐ I have done my best to ensure that all information provided on this application is correct.

☐ I have discussed this application with the applicant and obtained the applicant's knowledge and voluntary consent to make this referral.

☐ The applicant consents to the collection, use, and disclosure of the personal health information provided.

☐ The applicant understands that the personal health information provided on this application may be shared by relevant agencies included with The Access Point Northwest.

☐ The applicant consents to The Access Point Northwest to access medical records relevant to this application.

☐ The applicant consents that if the application is not accepted, it can be forwarded to a program outside The Access Point Northwest.

Name of Referrer: full name with credentials Agency/Department: _____

Contact Number: _____ Fax Number: _____

Please attach any relevant consult letters, test results, or other pertinent medical records.

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Contact Information (paste label over top of this section)

First/Given Names(s): _____ Last Name: _____

Address: _____

Phone Number: _____ Can leave message? ☐ Yes ☐ No

Alternate Number: _____ Can leave message? ☐ Yes ☐ No

Email: _____ Preferred Language: _____

Date of Birth: month / day / year Health Card #: _____

Gender: ☐ Female ☐ Male ☐ Other Indigenous? ☐ Yes ☐ No

Medical Contact

Does the applicant **have a primary care provider** (physician or nurse practitioner)? ☐ Yes ☐ No

Name: _____ Agency/Clinic: _____

Phone Number: _____ Fax Number: _____

Existing Supports

If the applicant is currently working with any **other service providers**, please list below:

Agency 1: _____ Agency 2: _____

Contact Name: _____ Contact Name: _____

Contact Number: _____ Contact Number: _____

Does the applicant have access to an **Employee Assistance Program**? ☐ Yes ☐ No

Has the applicant been referred for **other mental health programs**? ☐ Yes ☐ No

Reason for the Referral

*Please briefly describe the **reason(s) for the referral**, including any **clinical questions**, **diagnoses**, description of symptoms, requested services, support needs, etc.*

Primary Symptom: _____ Secondary Symptom: _____

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Chronic Pain

Date of on-set of the pain: month / day / year

Is the applicant **medically stable**? ☐ Yes ☐ No

Are there any barriers to learning? ☐ Yes ☐ No

Are there any barriers to working in groups? ☐ Yes ☐ No

Able to **participate in aerobic/muscle strengthening** exercise? ☐ Yes ☐ No

Does the applicant have a **history of chronic mental health** problems? ☐ Yes ☐ No

To what degree is the applicant's daily function impaired by pain?

☐ Mild (intermittent difficulties at home/work)

☐ Moderate (on-going difficulties at home/work, social activities, and psychosocial symptoms)

☐ Severe (unable to work, no social activities, severe/persistent psychological symptoms)

Please describe any restrictions for exercise and any medical conditions that would pose a barrier to participation in the program:

Interventions Requested:

☐ Diagnostic clarification

☐ Counseling/psychotherapy

☐ Psychosocial interventions

☐ Pain self-management education

☐ Anesthesia intervention

☐ Medication consultation

☐ Psycho-educational groups

☐ Sleep strategies

☐ Strategies to improve physical function

☐ Clinical questions: _____

☐ Other: _____

Requirements for Triage (relevant to reason for referral), please include:

- Medical history (co-morbidities).
- Copies of specialty consultations/pending appointments.
- Past/pending investigations.
- Copies of diagnostics (CT scans, MRIs, X-rays).
- Consultations/imaging outside of Meditech EMR.
- Last year of lab work.
- Description of current management plan (please include all current prescribed medication).

Additional comments: