Dr. Victoria E. Cook
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PATIENT INTAKE FORM, PEDIATRIC

Appointment Date		**Patient Name** As on care card	
Patient Date of Birth (dd/mm/yy)		**Patient Sex**	☐ Male ☐ Female
Patient Care Card # Required		**Pharmacy**	
Referring Dr.		**Family Dr.**	

Info	**Parent or Guardian 1**	**Parent or Guardian 2** Fill only fields different from parent or guardian 1
Relationship to Child		
Name		
Age		
Address		
City		
Province		
Postal Code		
Address		
City		
Primary Phone		
2nd Phone		
Email		
Parents living together?		☐ Yes ☐ No

MAIN CONCERNS / PROBLEMS

Please list or shortly describe what has brought you to the clinic, and how you would like us to help.
Some examples of concerns include: Runny or stuffy nose, asthma, hives, food allergy, wasps

PLEASE CONTINUE THIS FORM ON THE NEXT PAGE

OFFICE USE ONLY				
BP	P	Sp02	Height cm	Weight kg

MEDICAL HISTORY

Please circle the appropriate item(s), or fill in the space with a brief description if appropriate.

Did mother have any health problems during pregnancy?	☐ High Blood Pressure	☐ Diabetes	☐ Illness	Medications
	☐ Alcohol	☐ Drugs	☐ Smoking	Other (List)
When was the baby born?	☐ "Right Time"	☐ Premature	☐ Overdue	
Was the baby well at birth? If no describe briefly				
What was the birth weight?				
Did the baby have any problems in the newborn period?	☐ Breathing	☐ Feeding	☐ Jaundice	Other (List)
Has your child had all recommended vaccinations to date?	☐ Yes		☐ No	

MEDICAL PROBLEMS / SURGERIES

Please shortly list any medical problems, procedures, or surgeries

CURRENT MEDICATIONS

Please list any medications currently being taken

DEVELOPMENT

At what age did your child begin to	**Sit**	**Walk**	**Talk**
Current grade in school?			
Any school related problems?			
Any problems with friends?			

Family History

Please list any health problems associated with Parent 1 or Parent 2.

Please list any siblings, including ages and any sibling health problems.

PLEASE CONTINUE THIS FORM ON THE NEXT PAGE

REACTIONS TO MEDICATIONS

Circle if you have had a reaction to a medication listed, describe the reaction and how long ago you last had this reaction. Please add additional reactions to medications not listed

Drug	Reaction	How Long Ago
Penicillin		
Amoxicillin		

BEE / WASP STINGS

Symptoms With Sting
Circle all applicable

☐ Local swelling <20cm diameter	☐ Excessive swelling >20cm diameter	☐ Hives	☐ Shortness of Breath	☐ Loss of Consciousness

How long since your last reaction?	
Do you have an EpiPen?	

HOME ENVIRONMENT

In what type of home do you live?	☐ Apartment	☐ Basement	☐ House	☐ Town Home	☐ Mobile Home	Other (list)

Approximately how old is the home?		
Is there a history of water damage or mould in the home?	☐ Yes	☐ No
Is there carpeting in the home?	☐ Yes	☐ No
Is there carpeting in the bedrooms?	☐ Yes	☐ No
Please list any pets present in the home		
What form of heating is in the home?	☐ Forced Air ☐ Radiant ☐ Baseboard	Other (List)
How often is the bedding washed?		
Is there smoking in the home?	☐ Yes	☐ No

	Parent 1	Parent 2
What do you do for work?		
Do you have extended health benefits?		

FOR EASIER COMMUNICATION, PLEASE READ, FILL, INITITAL & SIGN THE ELECTRONIC COMMUNICATION CONSENT FORM ON THE NEXT 3 PAGES

ELECTRONIC COMMUNICATION CONSENT FORM

Completing this form is optional. It will allow us to more easily communicate with you through electronic means, including email, text message and video conferencing. If you are not comfortable using these forms of communication, we are happy to communicate with you via telephone.

PHYSICIAN INFORMATION:

Name:	Dr. Victoria E. Cook
Address:	130 - 3200 Shelbourne St., Victoria BC, V8P 5G8
Email (if applicable):	reception@allergyvic.com,
Phone (as required for Service(s)):	250-595-7844

The Physician has offered to communicate using the following means of electronic communication ("the Services"):

☒ Email	☒ Videoconferencing (Medeo)
☒ Text messaging (including instant messaging)	

PATIENT ACKNOWLEDGMENT AND AGREEMENT:

I acknowledge that I have read and fully understand the risks, limitations, conditions of use, and instructions for use of the selected electronic communication Services more fully described in the Appendix to this consent form. I understand and accept the risks outlined in the Appendix to this consent form, associated with the use of the Services in communications with the Physician and the Physician's staff. I consent to the conditions and will follow the instructions outlined in the Appendix, as well as any other conditions that the Physician may impose on communications with patients using the Services.

I acknowledge and understand that despite recommendations that encryption software be used as a security mechanism for electronic communications, it is possible that communications with the Physician or the Physician's staff using the Services may not be encrypted. Despite this, I agree to communicate with the Physician or the Physician's staff using these Services with a full understanding of the risk.

I acknowledge that either I or the Physician may, at any time, withdraw the option of communicating electronically through the Services upon providing written notice. Any questions I had have been answered.

Patient name:

Patient signature:	Date:
Witness signature:	Date:

APPENDIX

Risks of using electronic communication

The Physician will use reasonable means to protect the security and confidentiality of information sent and received using the Services ("Services" is defined in the attached Consent to use electronic communications). However, because of the risks outlined below, the Physician cannot guarantee the security and confidentiality of electronic communications:

- Use of electronic communications to discuss sensitive information can increase the risk of such information being disclosed to third parties.
- Despite reasonable efforts to protect the privacy and security of electronic communication, it is not possible to completely secure the information.
- Employers and online services may have a legal right to inspect and keep electronic communications that pass through their system.
- Electronic communications can introduce malware into a computer system, and potentially damage or disrupt the computer, networks, and security settings.
- Electronic communications can be forwarded, intercepted, circulated, stored, or even changed without the knowledge or permission of the Physician or the patient.
- Even after the sender and recipient have deleted copies of electronic communications, back-up copies may exist on a computer system.
- Electronic communications maybe disclosed in accordance with a duty to report or a court order.
- Videoconferencing using services such as Skype or FaceTime may be more open to interception than other forms of videoconferencing.

If the email or text is used as an e-communication tool, the following are additional risks:

- Email, text messages, and instant messages can more easily be misdirected, resulting in increased risk of being received by unintended and unknown recipients.
- Email, text messages, and instant messages can be easier to falsify than handwritten or signed hard copies. It is not feasible to verify the true identity of the sender, or to ensure that only the recipient can read the message once it has been sent.

Conditions of using the Services

- While the Physician will attempt to review and respond in a timely fashion to your electronic communication, **the Physician cannot guarantee that all electronic communications will be reviewed and responded to within any specific period of time. The Services will not be used for medical emergencies or other time-sensitive matters.**
- If your electronic communication requires or invites a response from the Physician and you have not received a response within a reasonable time period, it is your responsibility to follow up to determine whether the intended recipient received the electronic communication and when the recipient will respond.
- Electronic communication is not an appropriate substitute for in-person or over-the-telephone communication or clinical examinations, where appropriate, or for attending the Emergency Department when needed. You are responsible for following up on the Physician's electronic communication and for scheduling appointments where warranted.
- Electronic communications concerning diagnosis or treatment may be printed or transcribed in full and made part of your medical record. Other individuals authorized to access the medical record, such as staff and billing personnel, may have access to those communications.
- The Physician may forward electronic communications to staff and those involved in the delivery and administration of your care. The Physician might use one or more of the Services to communicate with those involved in your care. The Physician will not forward electronic communications to third parties, including family members, without your prior written consent, except as authorized or required by law.
- You and the Physician will not use the Services to communicate sensitive medical information about matters specified below [check all that apply]:
  - ☐ Sexually transmitted disease
  - ☐ AIDS/HIV
  - ☐ Mental health
  - ☐ Developmental disability
  - ☐ Substance abuse
  - ☐ Other (specify):
- You agree to inform the Physician of any types of information you do not want sent via the Services, in addition to those set out above. You can add to or modify the above list at any time by notifying the Physician in writing.
- Some Services might not be used for therapeutic purposes or to communicate clinical information. Where applicable, the use of these Services will be limited to education, information, and administrative purposes.
- The Physician is not responsible for information loss due to technical failures associated with your software or internet service provider.

Patient initials_____

APPENDIX CONTINUED

Instructions for communication using the Services
To communicate using the Services, you must:

- Reasonably limit or avoid using an employer's or other third party's computer.
- Inform the Physician of any changes in the patient's email address, mobile phone number, or other account information necessary to communicate via the Services.

If the Services include email, instant messaging and/or text messaging, the following applies:

- Include in the message's subject line an appropriate description of the nature of the communication (e.g. "prescription renewal"), and your full name in the body of the message.
- Review all electronic communications to ensure they are clear and that all relevant information is provided before sending to the physician.
- Ensure the Physician is aware when you receive an electronic communication from the Physician, such as by a reply message or allowing "read receipts" to be sent.
- Take precautions to preserve the confidentiality of electronic communications, such as using screen savers and safeguarding computer passwords.
- Withdraw consent only by email or written communication to the Physician.
- **If you require immediate assistance, or if your condition appears serious or rapidly worsens, you should not rely on the Services.** Rather, you should call the Physician's office or take other measures as appropriate, such as going to the nearest Emergency Department or urgent care clinic.
- Other conditions of use in addition to those set out above: *(patient to initial)*

I have reviewed and understand all the risks, conditions, and instructions described in this Appendix.
Patient signature
Date

Patient initials_____