Sudbury District Nurse Practitioner Clinics
www.sdnpc.ca
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30 Ste. Anne Road, 3rd Floor
Sudbury, ON P3C 5E1
P: 705-671-1661
F: 705-671-0177

623 Main Street
Lively, ON P3Y 1M9
P: 705-692-1667
F: 705-692-0177

100-200 Larch Street
Sudbury, ON P3E 1C5
P: 705-673-3721
F: 705-805-3660

Welcome to the Sudbury District Nurse Practitioner Clinics

Patient Registration Form – CHILD (0-17yrs)

Thank you for your interest in the Sudbury District Nurse Practitioner Clinics (SDNPC) and for filling out this application completely. If you are applying for an adult (aged 18+) you will need to request an adult intake form. *Please note, incomplete forms will not be processed*. Upon completion of this form, a nurse practitioner will review your information and invite you for a face to face visit to determine if your needs can be met at this clinic. All applications are assessed and prioritized by the Executive Director. We *aim* to schedule these visits within 6-12 months of application. In the case of a lengthy waiting list to access an intake appointment at their requested site, patients may be offered to become a patient at a different site than the site requested on the intake form.

**Please note, we are not able to refill any medications including narcotics, or address any of your medical concerns until after you have been accepted as a registered patient and formally enrolled in our primary care clinic. If you have any urgent concerns, please seek care at Health Sciences North or a walk-in-clinic. **

Patients are registered to the clinic and while they usually see one provider on a regular basis, they may be required to see alternate providers from time to time.

Sudbury District Nurse Practitioner Clinics has a Code of Conduct that sets boundaries for acceptable behaviour within our clinic. Acts of physical or verbal violence are not tolerated and may result in termination of services or discharge from the clinic.

I have read and understand this. **Please initial in the box** ☐ **DATE:** _____

Name (*Last, First*): _____

Preferred Site*: Lively ☐ Sudbury: St. Anne Site ☐ 200 Larch St. Site ☐

*Depends on capacity at that site; you may be offered a provider at a different location.

Who Is Completing This Form for the Child:

Mother ☐ Name: _____ Phone# _____

Father ☐ Name: _____ Phone# _____

Guardian ☐ Name: _____ Phone# _____

Other ☐ Name: _____ Relation: _____ Phone# _____

Childs Last Name: _____ First Name: _____ Middle Initial: _____

Childs Preferred Name (If Different from Legal Name)_____

Sex assigned at Birth: Male ☐ Female ☐

Gender Identity: Male☐ Female☐ Transgender☐ Two Spirit ☐ Non-Binary☐ Questioning ☐ No Answer ☐

Pronouns: He/Him☐ She/Her☐ They/Them ☐ Other: _____

Date of Birth (YYYY/MM/DD):_____ OHIP Number: _____ Version Code:_____

OHIP Expiry Date (YYYY/MM/DD):_____ Check Box If You Do Not Have an OHIP # ☐

Preferred Language: _____ Is a translator required? Yes☐ No ☐ If so, specify: _____

Address:_____ Apartment/Unit Number: _____ P.O Box _____

Town/City:_____ Prov: _____ Postal Code: _____

Home Phone: _____ Cell: _____ Work: _____

Email: _____ Preferred Method of Contact: Home ☐ Cell ☐ Work ☐ Email ☐

Emergency Contact Name_____ Relationship to Child _____

Emergency Contact Phone # _____

Name & Location of Previous Provider * _____

Reason for Leaving: _____

You will be required to de-roster from your provider if accepted to this clinic

When was the last time the child visited a Health Care Provider? _____ Who? _____

Has the child been hospitalized in the past 2 Years? Yes ☐ No ☐ Why? _____

Is the child Registered with Health Care Connect? * Yes ☐ No ☐

You will be required to remove their name from Health Care Connect if accepted to this clinic

Preferred Lab Location? LifeLabs: Larch ☐ Lasalle ☐ Long Lake Rd ☐ Other _____

Birth History:

Is child by: Birth ☐ Step-Child ☐ Adopted ☐ Foster ☐

Was the pregnancy full term? Yes ☐ No ☐ Unknown ☐; If Premature ☐ # of weeks_____ Unknown ☐

Any complications with the pregnancy/delivery? Yes ☐ No ☐ Unknown ☐

How much did your child weigh at birth? _____ Unknown ☐

Were prenatal vitamins taken? Yes ☐ No ☐ Unknown ☐

Were Drugs, alcohol, cigarettes used in pregnancy? Yes ☐ Specify: _____No ☐ Unknown ☐

Was prenatal care received throughout pregnancy? Yes ☐ No ☐ Unknown ☐

Social History: **Who does the child live with?** Both parents ☐ Mother only ☐ Father only ☐ Guardian ☐
Any Siblings? # & age_____ Other: _____ Pets in the home? _____
Any custody issues? Yes ☐ No ☐ Current School & Grade: _____ In daycare? _____

Growth & Development: Have you or previous providers had **any concerns with your child's development** (speech, language, social skills or motor skills?) Yes ☐ No ☐ If yes please explain: _____

Past Medical History*:* Has the child had any of the following conditions?

	Condition	Year Diagnosed		Condition	Year Diagnosed
☐	Abdominal problems		☐	A Serious Injury _____	
☐	Constipation		☐	Broken Bones	
☐	Kidney or Bladder infections		☐	Joint/Bone Problems	
☐	Heart Problems		☐	Seizure	
☐	Asthma		☐	Genetic disorder	
☐	Pneumonia		☐	Frequent Temper Tantrums	
☐	Cough		☐	School Problems	
☐	Hearing Problems		☐	Behavior Problems	
☐	Many ear infections		☐	Skills are behind other kids	
☐	Sinus Problems		☐	Speech/ Language delay	
☐	Vision Problems		☐	Picky Eater	
☐	Other _____		☐	Underweight	
☐	Other _____		☐	Overweight	

Any previous Surgeries? Yes ☐ No ☐ If yes, please list including year:
_____
_____

Immunizations ***Please provide a copy of immunization records/yellow card.**
Has your child received all recommended vaccinations for their age? Yes ☐ No ☐
If no, what is needed? _____

Diet/Exercise: How would you rate your child's physical activity? Good ☐ Fair ☐ Poor ☐
How much screen time per day? none ☐ Less than 1 hr ☐ Less than 2hrs ☐ 3+ hrs ☐
How would you rate your child's diet? Good ☐ Fair ☐ Poor ☐ Special diet? _____
Any use of: Alcohol ☐ Drugs ☐ Tobacco ☐ by child? Exposed to second hand smoke? Yes ☐ No ☐

Family Health History

Family Member of Child	Living (L) Deceased (D) Unknown (U)	Medical Condition (Examples; Diabetes Mellitus, Cancer & Type; High Blood Pressure; Heart Attack; Stroke, etc. Please Include Age at Diagnosis If Known)
Mother		
Father		
Mother's Mom		
Mother's Dad		
Father's Mom		
Father's Dad		
Sister		
Brother		

Medications & Supplements

Any Medications/Supplements taken frequently? Yes ☐ No ☐ If yes, please list in table below.

Medication Name *i.e. children's Tylenol/ Acetaminophen; Flintstones vitamin*	Dose/Amount *i.e. 500mg, 2tabs*	How Often *i.e. Twice Daily or As Needed (PRN)*	Time of Day *i.e. AM/Breakfast, Noon, PM/Supper, Bedtime*	Reason For Taking *i.e. fever*

What Best Describes Your Prescription Drug Coverage? (Check All That Apply)

None ☐ NIHB, Veterans Affairs, other Federal ☐ Seniors Drug Plan (ODB) ☐ Trillium ☐ ODSP ☐

OHIP+ (24yrs & Under) ☐ WSIB ☐ Private Insurance (i.e.Sunlife) ☐ _____

Do you find it difficult to afford the out of pocket cost of medications? Yes ☐ No ☐

Pharmacy Name, Location, Phone #_____

Any Allergies/Intolerances? Yes ☐ No ☐ Allergy Testing Done? Yes ☐ No ☐

If Yes Please List Allergen and Reaction Below: (Please Include Medication, Latex, Environmental)

Allergen: _____ Reaction: _____

Allergen: _____ Reaction: _____

Additional Health Care Providers

Does the child currently see a specialist (i.e. Pediatrician) for any health issues? Yes ☐ No ☐

Name: _____ Reason: _____ Date of Last Visit: _____

Name: _____ Reason: _____ Date of Last Visit: _____

Name: _____ Reason: _____ Date of Last Visit: _____

Any Other Information You Think Is Important for Us to Know: _____

How Did You Hear About Us? _____

I confirm the information I have provided in this form to be complete, truthful and accurate.

_____ _____

Signature Date (YYYY/MM/DD)