Ottawa Inner City Health

Health Care Agreement

I, _____, have accepted an offer of housing at _____(address) which includes access to health care services provided by Ottawa Inner City Health, Inc.

I understand that I have the right to give or refuse consent to treatment including medication in accordance with the law and to be fully informed of the consequences of giving or refusing consent.

If I require assistance with personal care, it may be provided by client care workers, who will be available at scheduled times. I will be given privacy during personal care and treatment.

I understand that volunteers and students are an integral part of *Ottawa Inner City Health* and will be available to help with my care.

I give consent and approval for documentation to be kept by *Ottawa Inner City Health*, while a client of the program. The documentation and medical records concerning my care will stored in electronic files. All medical records will be kept confidential within *Ottawa Inner City Health* and the partner organizations that work together to provide care to me.

I give consent to *Ottawa Inner City Health* to share the information contained in my health record with the health professionals involved in providing my care in order to provide high quality health care to me.

I understand that information about me that will be collected and used for research or evaluation of this program will not identify me personally and that all research conducted by *Ottawa Inner City Health* will concur with the guidelines for ethical research established by the University of Ottawa.

I agree to

- Accept health care services provided by Ottawa Inner City Health, Inc
- Maintain a valid health card and other entitlements needed for the delivery of health care
- Give permission to representatives of *Ottawa Inner City Health* to communicate directly with representatives of the Ontario Ministry of Health and Long Term Care regarding my health card number by telephone, in writing, email or fax. If I am unable to make an application for myself, I authorize representatives of *Ottawa Inner City Health* to make application for a health card or make changes to my health card records on my behalf. I authorize representatives of *Ottawa Inner City Health* to release my valid health card number to health care agencies who require this information to provide an insured service.

Ottawa Inner City Health

- Release *Ottawa Inner City Health*, from responsibility for lost or missing money or valuables.
- Work with *Ottawa Inner City Health* to maintain a safe, therapeutic environment for everyone to live and work. I agree to treat staff and other clients with respect and dignity and to behave lawfully and cooperatively. I understand that physical and mental abuse of staff or other residents cannot be tolerated, and I agree to report any concerns regarding the safety of myself or other clients.
- Appoint Powers of Attorney to handle my medical and legal affairs if I require one. I am aware that I can get assistance from the nurse if I wish to appoint a Power of Attorney.
- I understand that there is a complaint process that can be followed if I have a concern about the services that I receive.
- Work with the staff of *Ottawa Inner City Health* to protect my safety and, the safety of other residents. I understand that as part of my plan of care, staff from *Ottawa Inner City Health* may enter my housing unit for the purpose of providing health care to me without prior notice. I understand that the staff of *Ottawa Inner City Health* will do their best to balance my rights for privacy and safety and will negotiate a plan of care which is specific to my needs and respects my wishes.
- I consent to allowing the staff of *Ottawa Inner City Health* to have a key to my unit to allow them to enter the unit for the purposes of providing health care to me in accordance to my plan of care or where there is concern for my health or wellbeing.
- Follow the rules about smoking in my housing in accordance with the requirements of local bylaws and provincial regulations.

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_____ OR _____

Signature of Client

Signature of Power of Attorney

_____ _____

Witness

Date

Ottawa Inner City Health

Release of Information Consent to Share Information

In order to help me with my health and other needs I, _____,
DOB (dd/mm/yyyy): _____ authorize *Ottawa Inner City Health Inc* to request and/or send health and other relevant information to and from the following agencies or persons:

- ❑ Somerset West Community Health Centre
- ❑ Centretown Community Health Centre
- ❑ Sandy Hill Community Health Centre
- ❑ Canadian Mental Health Association
- ❑ University of Ottawa, Health Services
- ❑ Community Care Access Centre
- ❑ Centre 454
- ❑ Wabano Centre for Aboriginal Health
- ❑ AI
- ❑ Royal Ottawa Hospital
- ❑ St. Joseph's Women's Centre
- ❑ Shepherds of Good Hope
- ❑ Ottawa Withdrawal Management Centre
- ❑ The Ottawa Hospital
- ❑ _____ Family Doctor
- ❑ Ottawa Police
- ❑ Ottawa Paramedic Services
- ❑ John Howard Society-Ottawa Branch
- ❑ The Mission
- ❑ ACT Team_____
- ❑ The Well
- ❑ Salvation Army
- ❑ The Monfort
- ❑ _____
- ❑ _____
- ❑ Ontario Ministry of Health and Long Term Care

I understand that I can cancel this consent in writing at anytime by signing in the indicated space below.

_____
Signature of client/Power of Attorney

_____
Signature of Witness

Date Consent In Effect_____
(yy/mm/dd)

Date Consent Expires_____

(yy/mm/dd)

I wish to withdraw my consent to share information

_____

Signature of client/power of attorney

Ottawa Inner City Health

Ottawa Inner City Health Inc Client Rights and Responsibilities

Every patient of *Inner City Health* has the right:

- to be treated with respect, free from mental and physical abuse
- to be told who is providing health care
- to be given privacy during personal care and treatment
- to be informed of the medical condition, and proposed course of treatment
- to give or refuse consent to treatment including medication in accordance with the law and to be fully informed of the consequences of giving or refusing consent
- to designate a person to receive information concerning his/her health situation
- to reasonably pursue social, cultural, religious and other interests
- to live in a safe, clean environment
- to have all medical records kept confidential within *Inner City Health*

Every patient of *Inner City Health* has the responsibility:

- to treat staff and other clients with respect and dignity
- to behave lawfully and cooperatively
- to report any concerns regarding safety of self or other clients