Application for RISE Clinic

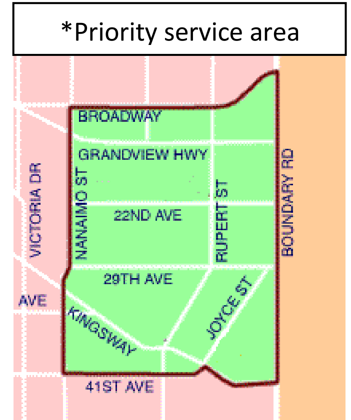
PLEASE SUBMIT THIS APPLICATION VIA EMAIL OR IN PERSON

Phone: 604-558-8090
Fax: 236-317-4270
Email: RISECHC@cnh.bc.ca
Website: www.cnh.bc.ca/RISE
Address: 5198 Joyce Street
Vancouver, BC V5R 4H1

INFORMATION:

- We provide ongoing medical care and support for general health concerns, social needs, mental health and addictions issues and coordination of specialist care
- Our team includes, family physicians, nurse practitioners, community health workers, nurses, medical office assistants and more
- The clinic's priority is to serve Renfrew-Collingwood community members who face social challenges and do not have a regular healthcare provider
- We are located at 5198 Joyce Street, Vancouver, with additional outreach services in the community
- RISE Community Health Centre provides additional services and initiatives for clinic clients, as well as for the broader community, see the website or call for details

*Priority service area



DATE: ________________________

CONTACT INFORMATION: Who is completing this form?

☐Self

☐CNH Internal Referrer's name: __________________________ Relation to applicant: ______________________

☐Friend or Family Referrer's phone: ______________________________Email: ________________________________

☐Agency/Provider Agency or department (if applicable): ____

Did the applicant consent to this referral? ☐YES ☐NO (we will not contact applicant without consent)

Applicant name:____ Pronoun:__________ Date of birth:________________
(First last) *(he, she, they, etc.)* *(month/day/year)*

Home address:____
(Unit #, street, postal code, city)

☐live alone ☐live with others ☐stable housing ☐unstable housing ☐homeless (includes shelters & couch surfing)

Phone:__________________________ Alternate Phone:__________________________Email: ______________________

Preferred method of contact: ☐phone ☐text ☐email ☐letter ☐Outreach *(where)*:__________________

Is it ok to leave a message? ☐Yes ☐No

Does applicant require language interpretation? ☐NO ☐YES *If yes, language*?____________________________

Is the applicant requesting support for any other family members? ☐NO ☐YES (*Fill out a separate form for each member)*

Where has the applicant been getting most of their medical care from in the last year?

☐Family doctor/Family Nurse Practitioner Walk-in clinic; name: ____________________________

☐I have not had any medical care in the last year Clinic address:_________________________________

☐Hospital Name:____

(OVER)

Application for RISE Clinic

BARRIERS:

Is the applicant experiencing any barriers to accessing a regular health care provider? (Check all that apply)

☐Lack of support or social isolation
☐Financial distress
☐Lack of stable/adequate housing
☐Homebound/lack of transportation
☐Trouble navigating healthcare system
☐Abuse or violence
☐Discrimination on basis of culture, race, gender Identity, sexual orientation, or other
☐Lack of childcare
☐Language or cultural barriers
☐Other:____________________________________

MEDICAL INFORMATION:

Does the applicant have any of the following medical conditions? (Check all the apply)

☐Chronic disease (Diabetes, Heart Disease, etc.)
☐Infectious disease (HIV, Hepatitis C, etc.)
☐Mental illness (Depression, Anxiety, Bipolar, etc.)
☐Substance use disorder (Alcohol, Drugs, Tobacco etc.)
☐Developmental disability (Autism, Cerebral palsy etc.)
☐Mobility impairment (wheel chair, walker, etc.)
☐Sensory impairment (vision or hearing loss, etc.)
☐Prefer not to answer
☐Do not know
☐Other:_____________________________________

Which type of medical coverage does the applicant have? (Check all that apply):

☐BC Health Care
☐Extended medical benefits (dental, vision, etc.)
☐Interim Federal Health benefits
☐Non-Insured Health Benefits (First Nations Status)
☐Premium Assistance
☐Out of province health care coverage
☐International student or travel medical insurance
☐I do not have health insurance
☐I do not know
☐Other:______________________________________

What services is the applicant interested in? (Check all that apply)

☐Primary care (family doctor or nurse practitioner)
☐Group health education/activities
☐Nutrition/Dietitian
☐Help navigating the health care system
☐Social Worker
☐Occupational therapy
☐Counselling
☐Physiotherapy
☐Physical activity
☐Other:_____________________________________

Is one or more of the applicant's family members a client of RISE clinic? ☐NO ☐YES *(If yes please list names below)*

Name(s): ____

Once your application has been received, a staff member will follow up with you to discuss your application. Applications will be prioritized based on fit to RISE Clinic's mandate to serve Renfrew-Collingwood Community members with barriers to accessing primary care.

For Office Use Only: ☐ Rostered ☐ Not Rostered

Comments: ____

Response Sent: ☐NO ☐YES Date: _________________ Signature: ___________________