Modified January 2016

Office Use Only
Sustainable Clinic Site:

IDHC Personal and Personal Health Information Notice and Consent

NOTICE

This Notice is to inform you how the Indigenous Diabetes Health Circle ("IDHC") will collect, use, and disclose of your personal information and personal health information.

IDHC will collect, use, and disclose information about you for the following purposes.

- To enable IDHC to contact you and provide necessary services, if your application is accepted.
- To provide specific information into a data collection system, specific to the program(s) in which you participate. This information relates to program statistics and reporting, is in compliance with the Personal Health Information Protection Act (PHIPA) and does not involve the release of your personal information.

All employees and contractors at IDHC are sworn to an Oath of Confidentiality.

Any complaints about how your personal health information is collected, used or disclosed may be filed with IDHC's Executive Director.

Only necessary information is collected about you. Your information is only shared by written consent. The storage, retention, and destruction of your personal and personal health information complies with IDHC 's file maintenance policy, applicable legislation and privacy protection protocols, to ensure its confidentiality.

If your personal health information is used in studies, research, or reports on issues specific to Aboriginal peoples, no identifiable information will be used.

Your signature is consent to the collection, use, disclosure and destruction of your personal and health information only for the purposes listed. Other uses require your specific consent.

Your consent may be withdrawn at any time by notice to IDHC.

You may place conditions or restrictions on your consent with respect to how your personal health information is shared with other custodians.

IDHC and any other custodian is permitted to disclose your personal health information for the purpose of eliminating or reducing significant risk of serious bodily harm to an individual or group of persons.

You may access your own personal health information, or request corrections, through a written request to IDHC or its Executive Director.

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CONSENT

Always complete this part if the Client is capable of consent.

I, _____ ("the Client") have read and understood the preceding Notice
(please print)
and had it explained to me. I am aware how IDHC will use my personal health information. I am also aware of the steps taken by IDHC to protect my information, when it is collected, used or disclosed, as well as how it will be stored and destroyed. I consent to the provisions of the preceding Notice, and any conditions or restrictions to my consent are signed, dated, and attached to this Consent in written form.

Signature: _____ Witness: _____

Date: _____

Complete this part if the Client is under 16 years of age, is incapable of consent, or if an individual has been assigned to act on his or her behalf.

I am the _____ of the Client, _____. I have read and
(please print) *(please print)*
understood the preceding Notice and had it explained to me. I consent on behalf of the Client to the provisions of the preceding Notice, and any conditions or restrictions to my consent are signed, dated, and attached to this Consent in written form. In so doing, I have taken into consideration:

a) The wishes, values and beliefs that I know the Client holds and that I believe the individual would want reflected in decisions made concerning the Client's personal health information;

b) Whether the benefits that I expect from the collection, use or disclosure of the information outweigh the risk of negative consequences occurring as a result of the collection, use or disclosure;

c) Whether the purpose for which the collection, use or disclosure is sought can be accomplished without the collection, use or disclosure; and

d) Whether the collection, use or disclosure is necessary to satisfy any legal obligation.

Signature: _____ Date: _____

Name: _____ Witness: _____
(please print)

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Subsidized Foot Care Application

Name:			Date:
Mailing Address:			
Date of Birth:			☐Male ☐ Female ☐ Two-spirited
Age:	Shoe Size:	☐Wide ☐Medium	☐Narrow
Phone Number: ( )		Email:	

Identify as: ☐Status Native ☐ Non-Status Native ☐ Métis ☐ Inuit ☐ Other

Reserve:_____ Métis/Status Card #:_____

What is your diabetes status? ☐ Diabetic (____ # yrs.) ☐Not Diabetic ☐Pre- diabetic

☐ At Risk-family history-please list:_____

Medications:_____

Have you attended a IDHC Foot Clinic in the past? ☐Yes ☐No/ Unsure

If applicable, **Previous Foot Care Services** included:

☐Foot Care Nurse ☐Chiropodist/Podiatrist ☐Reflexology
☐Orthopaedic Surgeon ☐Pedorthic (Orthotics) ☐Other (explain):_____

Previous foot care services covered by:

☐Insurance (benefits, private) ☐Non-Insured Benefits (NIHB) ☐Social Services (ODSP/OW, Welfare)

☐Out-of-pocket ☐Other:_____

Reason for previous foot care service:_____

Date of last foot care service (month, year):_____

Name of Past foot care provider:_____

IDHC Head Office
3250 Schmon Parkway, Unit 1B, Thorold, ON L2V 4Y6
Tel: 1 888 514 1370 · Fax: 1-866-352-0485
Web: www.idhc.life

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Current Foot Care Concerns include:

☐ Nail concerns ☐ Skin Concerns ☐ Bone Structure Concerns ☐ Wide Feet

☐ Infection/ Wound ☐ Pain/ Loss of Sensation ☐ Swelling ☐Other

Please explain your concern(s): _____

_____

Do you have access to health care coverage?

☐ No ☐ Yes (explain and list):_____

Are there any mobility issues or concerns?

☐ No ☐ Yes (explain):_____

Name of Client Representative:

_____

Phone/ Email:

_____

Foot Care Provider Name:

_____

Phone:

_____

Please input this data into our online application form after you've fax in the consent form.

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