Grand Bend Area Community Health Centre

Social Work Counselling Consent-Intake Form

COUNSELLING

The Grand Bend Area Community Health Centre (GBACHC) social work (SW) program offers individual appointments for brief solution-focused counselling. Social workers skilled in counselling meet with clients who would like to obtain a positive mental health outlook. Each appointment is 45 minutes to 1 hour in length. Clients are asked to arrange for their own childcare during appointment times. The counselling process may be emotionally upsetting, the SW program is committed to helping clients through difficult times.

Clients are asked to use their own employee assistance program (EAP) services through their employer benefit package prior to receiving counselling services at the GBACHC. An employer EAP program provides an outline of the number of counselling visits available and will work to find a counsellor close to the client's home. Working with an EAP program first ensures the client receives service in a timely manner and helps to develop steps to manage their situation.

The GBACHC requires 24-hours notice for cancelling appointments with the SW program. For convenience, clients may leave a message 24 hours a day. **If an appointment is missed, it is the client's responsibility to contact their social worker within two weeks to reschedule the appointment. The client's file will be closed if they have not rescheduled within the two-week period. Clients may reapply for service at any time**. If multiple appointments are missed, the social worker will reassess the client's readiness for counselling.

The SW program partners with community agencies to provide care including Choices for Change, the Canadian Mental Health Association and confidential virtual counselling.

Counselling at the GBACHC is compliant with provincial and federal regulations and legislations as applicable. The GBACHC is a fully accredited healthcare facility.

CONFIDENTIALITY, PRIVACY, AND COLLECTION OF INFORMATION

The GBACHC collects personal health information (PHI) about clients and family members in accordance with provincial and federal legislation. Client PHI privacy is protected and used by the SW program to provide excellent care. A client's file may be reviewed for a chart audit by the GBACHC staff as per accreditation standards and expectations. Client records are stored in a locked, secure area and in an electronic medical record (EMR), which is highly encrypted. Clients may request to see their EMR at any time by contacting the GBACHC privacy officer.

When the client provides consent, the SW program may use e-mail to schedule, confirm or cancel an appointment. Please note, e-mail is not a secure, private, or confidential form of communication. The GBACHC cannot guarantee the security of e-mail messages sent to or received from staff. **Clients are asked to never use e-mail in a crisis.** Sensitive information and photographs attached to an e-mail should be password protected. E-mail attachments will be deleted from GBACHC devices after the information has been added to the client's EMR.

The GBACHC will not release PHI unless the client provides written or verbal consent. If another person has attended the client's appointment, the other person may request the clinical report by contacting the GBACHC privacy officer.

CONSENT TO LIMITS TO CONFIDENTIALITY

The GBACHC will release client information without consent in the following circumstances:

1. The social worker believes that the client or someone else is at imminent risk of suicide or homicide.
2. A child under 16-years of age may be at risk of abuse or neglect.
3. The GBACHC has been subpoenaed by a court of law (court order) or a judge.
4. The GBACHC is presented with a search warrant.
5. There are reasonable grounds that the client may not be able to drive safely.
6. There is a need to consult with the social work team.
7. There is a need to consult with other staff at the GBACHC.

CRISIS INFORMATION

The SW program **DOES NOT** provide crisis counselling. Appointment frequency and duration is determined by the social worker and the client. **Clients are asked not to e-mail their social worker when in crisis.**

In the event of a crisis, the following may be contacted:

- Huron Perth Helpline & Crisis Response Team: 1-800-829-7484
- Distress Line, Sarnia Lambton: 1-888-347-8737
- (1-888-DISTRESS) Kids Help Phone: 1-888-688-6868
- Call a friend or family member – this person or persons should be trustworthy and safe
- **Call 911 or go to the nearest emergency room**

If couple's counselling is required following a domestic violence situation, call one of the following (the GBACHC does not provide this service):

- Lambton County – Family Counselling Centre: 1-844-864-8343
- Huron County – Family Services Perth-Huron: 1-800-268-0903
- Huron Women's Shelter Emergency 24/7 Access: 1-800-265-5506

OTHER CRISIS PHONE NUMBERS

- Ontario Crisis and Referral Line for Male Survivors of Sexual Abuse or Assault: 1-866- 887-0015
- Ontario Problem Gambling Helpline:1-888-230-3505
- Drug and Alcohol Treatment Infoline: 1-800-565-8603
- Tele-Health Ontario: 1-866-797-0000
- LGBTQ + Crisis Hotline; The Trevor Project: 1-866-488-7386
- Translifeline: 1-877-330-6366 or www.translifeline.org
- 211 Ontario: dial 2-1-1

PATIENT/CLIENT BILL OF RIGHTS

Grand Bend Area Community Health Centre (GBACHC) staff and volunteers make the following commitment to patients/clients:

Patients/Clients have the right:

1. To be treated with dignity, courtesy and respect in a manner that fully recognizes their dignity and individuality without discrimination.
2. To privacy and confidentiality in all matters.
3. To be treated in a safe and secure environment.
4. To know who is responsible for their care and who is providing their treatment.
5. To be informed of their medical condition, treatment and proposed course of treatment.
6. To participate in making any decision and in obtaining another opinion in any aspect of their care.
7. To give or refuse consent to treatment, including medications, and to be informed of the consequences of giving or refusing consent.
8. To have a designate in place to receive information concerning their care.
9. To have access to the information retained in their patient/client file, except when it is reasonable to believe that such access would result in a substantial risk to the physical, mental or emotional health of the patient/client or harm a third party.
10. To be aware of the procedures for initiating a complaint.

PATIENT/CLIENT CODE OF RESPONSIBILITY

Just as staff and volunteers make commitments to patients/clients, patients will have responsibilities to ensure that the GBACHC services run smoothly, and that patients/ clients and community members receive the most benefit from the care offered.

Patients/Clients have the responsibility:

1. To keep appointments to the best of their ability or cancel them in a timely fashion (24 hours notice).
2. To arrive 10 minutes before a scheduled appointment with a health card for registration.
3. To follow mutually agreed upon treatment plans.

4. To let their health care provider (physician, nurse practitioner, social worker, therapist) know if they are no longer following treatment plans.
5. To share important information necessary for their care including the use of other health care providers.
6. To follow community group guidelines developed for healthy group interactions.
7. To refrain from intoxication or from being under the influence of any substance(s) when visiting the GBACHC.
8. To respect the professional relationship with GBACHC providers and program leaders.
9. To be rostered to only one physician at a time.
10. To behave in a respectful and non-threatening manner towards staff and other patients/clients of the GBACHC on the phone and in person.

CLIENT KEEPS PAGES 1 to 5

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CONSENT TO COUNSELLING

Section 1: Consent to Receive Counselling

I, the undersigned (print name): _____

I understand and consent to the counselling conditions outlined on page 1 to 4 of the Social Work Counselling Consent-Intake Form. I recognize that counselling is a collaborative process. I agree to communicate with my social worker regarding my goals and progress.

Section 2: Patient/Client Code of Responsibility

I understand that failure to adhere to the patient/client code of responsibility will result in a verbal warning. If the behaviour continues, I will receive a written letter. A third instance of failure to adhere to the patient/client code of responsibility will result in the termination of my relationship with the GBACHC.

Section 3: Consent and Limits to Confidentiality

☐ I give permission to the GBACHC staff to communicate with me at this e-mail address:_____

☐ I give permission to the GBACHC staff to leave a message on my voicemail.

☐ I give permission for virtual appointments.

The GBACHC may release my information legally without consent as follows:

1. The social worker believes that I or someone else is at risk of suicide or homicide and there is prevention information available.
2. A child under 16-years of age may be at risk of abuse or neglect.
3. The GBACHC has been subpoenaed by a court of law (court order) or a judge.
4. The GBACHC is presented with a search warrant.
5. There are reasonable grounds that I may not be able to drive safely.
6. There is a need to consult with the social work team.
7. There is a need to consult with other staff at the GBACHC.

Client Signature: _____ Date: _____

Social Worker's Name and Credentials: _____

Social Worker's Signature: _____ Date: _____

Scanned to EMR on date_____ Admin staff signature_____

Section 4: Emergency Contact Information

By providing my emergency contact information, I am consenting for the GBACHC to contact the person identified below if there is an emergency. Emergencies include areas where limits of confidentiality apply such as medical distress, or there is a risk to myself or others.

The person named will not be contacted unless the reasons meet the limits of confidentiality. The person will not attend the counselling appointment with me. I will ensure that the person named below is aware that they are my emergency contact.

Emergency Contact Name: _____

Phone Number: _____ Relationship to Me: _____

Client Name: _____

Client' Signature: _____ Date: _____

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CLIENT DEMOGRAPHICS

Name: _____ Date: _____

Date of Birth: _____ Marital Status: _____

Health Card Number: _____ Gender: _____

Address: _____ City: _____

Postal Code: _____ Phone Number: (___)_____

Additional Phone Number: (___)_____

A message may be left at this number: ☐ Yes ☐ No

☐ I give permission to the GBACHC staff to communicate with me by e-mail at this e-mail address:

_____

Referred by: _____ Contact: (___)_____

I am currently employed at: _____

I am enrolled in school at: _____

I am currently accessing the following (check all that apply):

☐ ODSP ☐ Ontario Works ☐CPP ☐ Food Bank ☐ Other: _____

I have access to transportation: ☐ Yes ☐ No

I am seeking counselling for the following reasons (brief description):

_____

_____

_____

_____

Scanned to EMR on date_____ Admin staff signature_____

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Thinking About Change?

What changes are you considering? _____

1. How important is it that you make this change?
   (Circle the number indicating your readiness for counselling and making changes.)

0 1 2 3 4 5 6 7 8 9 10

Not important Extremely important

2. How confident are you that you can make this change?

0 1 2 3 4 5 6 7 8 9 10

Not confident Extremely confident

3. How ready are you to make this change?

0 1 2 3 4 5 6 7 8 9 10

Not at all Extremely ready

Preferred Appointment Time: ☐ Morning ☐ Afternoon ☐ No preference

Are you committed to attending individual counselling? ☐ Yes ☐ No

Have you received counselling at the GBACHC in the past? ☐ Yes ☐ No

Family Physician: _____ Phone: _____

Psychiatrist (if applicable): _____ Phone: _____

Have you ever had a diagnosis or received treatment for a mental illness? ☐ Yes ☐ No

If yes, please indicate the diagnosis: _____

Please list other healthcare professionals and/or community agencies seen:

_____

Scanned to EMR on date_____ Admin staff signature_____

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Please circle any that apply to you.

Abuse: Sexual, Physical, Emotional	Easily Angered	Loss of Interest	Risky Activity
Anxiety	Excessive Energy	Low Self Esteem	Substance issues
Bullying	Fatigue	Memory Impairment	Second Guessing
Caregiver stress	Grief	Panic Attacks	Self Harm
Changes in Appetite	Guilt	Parenting Concerns	Suicidal Thoughts
Changes in Sleep	Irritability	Persistent Pain	Trouble Controlling Emotion
Crying Spells	Insomnia	PTSD	Other:
Depression	Lack of Motivation	Relationship Concerns	

Please list prescriptions, over-the-counter medication(s), and/or herbal supplements/vitamins you are taking:

Drug Name	How often do you take it?	What is the dosage?	Why do you take it?

Scanned to EMR on date_____ Admin staff signature_____