



Brookline Collaborative Care Clinic

NEW PATIENT INTAKE PACKAGE

Please complete all sections of this package for each family member joining our clinic. Once completed, you may return the form directly to our office or submit it securely through our website.

To upload your completed form online, visit www.brooklinecares.ca and create or sign in to your Brookline Cares Member Account. Once signed in, visit the Help Centre and click the Onboarding button to securely upload your completed intake package directly into our system.

Legal First and All Given Names: _____

Legal Last Name: _____

Preferred Name: _____

Date of Birth (YYYY-MM-DD): _____

Sex at Birth: ☐ Female ☐ Male

Gender Identity: _____

Pronouns: _____

Health Card Number: _____

Expiry Date: _____

Home Address: _____

City: _____ **Province:** _____ **Postal Code:** _____

Mailing Address (if different): _____

Primary Phone: _____

☐ Mobile ☐ Home ☐ Work

Alternate Phone: _____

Email for our Communication Portal set-up: _____

Permission to Leave Voicemail: ☐ Yes ☐ No

Patient First and Last Name: _____ DOB: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____
Phone: _____ Alternate Phone: _____

PRIMARY CARE HISTORY

Are you currently on the Need a Family Practice Registry (811 List)? ☐ Yes ☐ No

Previous Family Physician/Nurse Practitioner: _____

Clinic Name: _____

City/Province: _____

Approximate Dates of Care: _____

Reason for Transfer (optional): _____

Consent to Request Medical Records: ☐ Yes ☐ No

CURRENT HEALTH CONCERNS

Please list your main current health concerns or goals:

1. _____
 2. _____
 3. _____
-

PAST MEDICAL HISTORY

- ☐ COPD
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Stroke/TIA
- ☐ Hypertension
- ☐ Asthma
- ☐ Thyroid Disease
- ☐ Cancer (type): _____
- ☐ Mental Health Diagnosis: _____
- ☐ Chronic Pain Condition
- ☐ Other: _____

Patient First and Last Name: _____ **DOB:** _____

RECENT Hospitalizations (include dates & reasons):

Surgeries/Procedures (include dates):

MEDICATIONS

Prescription Medications (name, dose, frequency):

1. _____
2. _____
3. _____
4. _____
5. _____

Over-the-Counter Medications:

Vitamins/Supplements/Herbal Products:

Pharmacy Name & Location with street name: _____

Pharmacy Phone (if known): _____

ALLERGIES & INTOLERANCES

Medication Allergies and Reaction:

Patient First and Last Name: _____ **DOB:** _____

Food Allergies and Reaction :

Environmental Allergies and Reaction :

☐ No Known Allergies

IMMUNIZATION HISTORY

☐ Unsure

COVID-19 Vaccines (last date) : _____

Influenza (last date): _____

Tetanus (last date): _____

Childhood Immunizations Complete: ☐ Yes ☐ No ☐ Unsure

Other: _____

FAMILY HISTORY

Indicate significant conditions in first-degree relatives:

Condition	Mother	Father	Sibling	Grandparent
Heart Disease	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Other	☐	☐	☐	☐

Details: _____

SOCIAL HISTORY

Patient First and Last Name: _____ **DOB:** _____

Occupation: _____

Employer/Industry: _____

Living Situation: ☐ Alone ☐ With Family ☐ With Partner ☐ Assisted Living ☐ Other

Tobacco Use: ☐ Never ☐ Former ☐ Current

If current/former — amount & years: _____

Alcohol Use: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Approximate drinks/week: _____

Recreational Drug Use: ☐ No ☐ Yes — type: _____

Exercise Level: ☐ Low ☐ Moderate ☐ High

Diet Pattern: ☐ No Restrictions ☐ Vegetarian ☐ Vegan ☐ Diabetic ☐ Other

PREVENTIVE HEALTH & SCREENING

Last Pap Test (if applicable): _____

Last Mammogram: _____

Last Colon Cancer Screening: _____

Last Bone Density: _____

Blood Pressure Check in Last Year: ☐ Yes ☐ No

Cholesterol Checked in Last 5 Years: ☐ Yes ☐ No

MENTAL HEALTH & WELLNESS SCREEN

Over the past 2 weeks, have you experienced:

- ☐ Persistent low mood
- ☐ Loss of interest or pleasure
- ☐ Anxiety or panic
- ☐ Sleep problems
- ☐ Thoughts of self-harm

Would you like to discuss mental health supports? ☐ Yes ☐ No

Patient First and Last Name: _____ DOB: _____

FUNCTIONAL & SAFETY SCREEN

- ☐ Difficulty with daily activities
- ☐ Falls in past year
- ☐ Mobility concerns
- ☐ Memory concerns
- ☐ Feel unsafe at home

Details: _____

COMMUNICATION & ACCESSIBILITY NEEDS

Preferred Language: _____

Interpreter Required: ☐ Yes ☐ No

Accessibility needs: ☐ Hearing ☐ Vision ☐ Mobility ☐ Cognitive ☐ Other

Details: _____

PATIENT DECLARATION

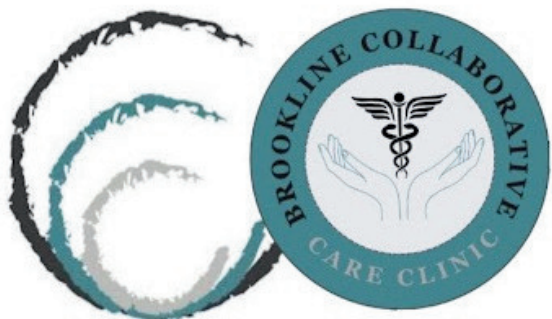
I confirm the information provided is accurate to the best of my knowledge.

Patient Name: _____

Signature: _____

Date: _____

For patients age 11 or younger, or patients who are unable to provide consent themselves, the required consents may be completed by a parent, legal guardian, or authorized substitute decision-maker, as applicable.



Patient Code of Conduct Agreement

Brookline Collaborative Care Clinic is committed to providing safe, respectful, ethical, and compassionate care to every patient. Our team practices in alignment with the standards and expectations of Doctors Nova Scotia, the Nova Scotia Department of Health and Wellness, and the Nova Scotia College of Nursing, along with other applicable professional and regulatory bodies. To ensure a safe and supportive environment for patients, staff, and visitors, all patients are required to read and agree to this Code of Conduct as part of their clinic onboarding.

OUR COMMITMENT TO YOU

- Treat every patient with dignity, fairness, respect, and compassion
- Provide care in a safe, inclusive, and professional environment
- Deliver patient-centered, collaborative care
- Protect your privacy and confidentiality in accordance with applicable laws
- Communicate clearly and respectfully
- Practice within regulated professional standards and scopes of practice
- Support continuity and quality of care

PATIENT RESPONSIBILITIES

- Treat all clinicians, staff, and other patients with courtesy and respect
- Communicate honestly and provide accurate and complete health information
- Participate in your care plan and discuss concerns respectfully
- Follow clinic policies and procedures
- Respect professional boundaries
- Attend scheduled appointments or provide appropriate cancellation notice
- Use phone, email, and electronic communication appropriately
- Follow safety and infection-control instructions when requested

ZERO TOLERANCE FOR ABUSE OR DISRESPECT

- Bullying or intimidation
- Harassment or discrimination
- Verbal abuse, yelling, or aggressive language
- Threats or threatening gestures
- Physical aggression or violence
- Sexual harassment or inappropriate remarks
- Repeated disruptive or hostile conduct
- Damage to clinic property
- Abusive phone, voicemail, email, or online messages

CONSEQUENCES OF UNACCEPTABLE BEHAVIOR

If unacceptable behavior occurs, the clinic may take appropriate action, including verbal or written warnings, immediate termination of an appointment, communication restrictions, removal from clinic premises, discharge from the practice in accordance with provincial guidelines and continuity-of-care obligations, and contacting security or law enforcement where safety is at risk.

REGULATORY AND PROFESSIONAL COMPLIANCE

Clinic providers and staff are regulated professionals who must comply with provincial healthcare legislation, regulatory college standards and codes of ethics, scope of practice requirements, and workplace safety laws. Patients may not require staff to act outside their legal or professional obligations.

ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and understand the Brookline Collaborative Care Clinic Patient Code of Conduct. I agree to follow these expectations as a condition of receiving care at this clinic.

Patient Name: _____

Date of Birth: _____

Signature: _____

Date: _____

***For patients age 11 or younger, or patients who are unable to provide consent themselves, the required consents may be completed by a parent, legal guardian, or authorized substitute decision-maker, as applicable. ***



Patient Consent for AI-Assisted Clinical Documentation

Purpose of This Consent

Brookline Collaborative Care Clinic uses a secure, healthcare-approved artificial intelligence (AI) documentation assistant called Heidi to support physicians and clinical staff with visit documentation. This consent form explains how the tool is used and asks your permission to use it during your appointments.

What Is Heidi AI Documentation Support?

Heidi is an AI-powered clinical documentation tool that helps reduce the amount of typing and manual note-writing required during your visit. It allows your physician to spend more time focusing on you, your concerns, and your care rather than computer data entry.

Heidi assists by:

- Converting clinical conversation into structured visit notes
- Drafting documentation for the medical record
- Supporting accuracy and completeness of charting
- Reducing administrative burden during appointments
- All final notes are reviewed and approved by your physician before being saved to your medical record.

Privacy and Security

Your privacy is important to us. The Heidi AI tool is configured for clinical use and follows strict security standards.

- Heidi does not record your name or personal identifiers
- Heidi does not create a separate patient profile
- Heidi does not store identifying information outside our clinical systems
- The tool processes visit details only for documentation purposes
- All documentation is stored securely within our EMR system
- Your physician reviews and confirms all notes before they become part of your chart

What This Means for Your Visit?

If you consent:

- AI-assisted documentation may be used during your visit
- Your clinician may use this tool to help prepare your chart note
- Your care and clinical decision-making remain fully directed by your healthcare provider



Privacy and Security

If you do not consent:

- Your clinician will document your visit manually
- Your care will not be affected
- You may change your decision at any time

Your Choice

Please select one:

- ☐ I consent to the use of AI-assisted documentation tools (Heidi) during my clinical visits.
- ☐ I do NOT consent to the use of AI-assisted documentation tools during my clinical visits.

ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and understand the Brookline Collaborative Care Clinic Patient Consent for AI-Assisted Clinical Documentation. I understand that my choice is voluntary, that my care will not be affected if I do not consent, and that I may change my decision at any time.

Patient Name: _____

Date of Birth: _____

Signature: _____

Date: _____