RAAM Clinic Toolkit

RESOURCES SPECIFIC TO FIRST CLINICAL VISIT

SECTION CONTENTS

Introduction
Arranging a Frst Appointment
RAAM Clinic Referral Template
Flow of First Appointment
First Appointment Checklist
Intake Form
Standard Intake Lab Requisition
HIV Serology Lab Requisition
Client Paperwork

INTRODUCTION

There are many considerations when planning for a client's first visit. Ideally, the client will feel welcome, safe, and engaged, which means orienting them to treatment options and available services without overwhelming them. This section describes the typical first visit and provides relevant materials for both clients and providers. All form templates should be considered suggestions. While not all clinics implement each of these types of forms, the intention is to provide a comprehensive set of documents that clinics can consider and draw from.

ARRANGING A FIRST APPOINTMENT

Drop-in clinics are open to all individuals seeking support for a substance-related concern. Initial appointments can also be arranged through clinician/agency referral using the **RAAM clinic referral template** (see following page), through the referring agency's own form, or through client self-referral via a call to reception. Clinics that offer booked appointments can provide referred clients with appointment times. Clinics that offer only drop-in hours can advise clients of these windows of time.

RAAM CLINIC REFERRAL TEMPLATE[1]

RAPID ACCESS ADDICTION MEDICINE CLINIC REFERRAL FORM

Phone: ____________________ Fax: ____________________

Address: ____________________

CLIENT INFORMATION

Name: ____________________ Phone: ____________________

Date of birth: ____________________ Health Card #: ____________________

Address: ____________________

Can a confidential message be left? ☐ Yes ☐ No Referral discussed with client: ☐ Yes ☐ No

Alternative contact #: ____________________

REFERRAL SOURCE INFORMATION

Individual/agency making referral: ____________________

Relationship to client/role: ____________________

OHIP billing # if applicable: ____________________

Phone: ____________________ Fax: ____________________

Primary care provider name if available: ____________________

Primary care phone: ____________________ Primary care fax: ____________________

OAT provider name if applicable: ____________________

OAT provider phone: ____________________ OAT provider fax: ____________________

REASON FOR REFERRAL

____

____

[1] Adapted from materials provided courtesy of the Northwestern Ontario Regional RAAM Steering Committee.

SUBSTANCES OF CONCERN (check all that apply)

- ☐ alcohol
- ☐ benzodiazepines (e.g., alprazolam/Xanax, diazepam/Valium)
- ☐ cannabis
- ☐ opiates (e.g., fentanyl, hydromorphone/Dilaudid)
- ☐ stimulants (e.g., cocaine/crack, methamphetamines)
- ☐ other: ______________________________

____

RELEVANT PSYCHIATRIC HISTORY/MENTAL HEALTH HISTORY

____

____

RELEVANT MEDICAL HISTORY

____

____

MEDICATIONS

____

____

ALLERGIES

____

____

Signature ______________________ Date ______________________

FLOW OF FIRST APPOINTMENT

Some clinics ask clients to fill out a form (see below) for their first appointment, which provides clients with an opportunity to describe for themselves their substance(s) of concern, current health status, symptoms of withdrawal, and goals for treatment. Based on the answers to these questions, along with physical presentation of observable symptoms, the client may be seen by one or multiple members of the care team. If clients are asked to fill out a form, the team should be alert to issues around literacy, privacy, and physical/psychological discomfort.

At the end of the visit, a clear follow-up plan should be made and communicated to the client. This can be managed by booking an appointment with the appropriate team member(s) and giving the client a card with the date and time of their appointment, or by giving the client a card to hand to the medical secretary to book the follow-up visit with the appropriate team member(s) within a particular time frame. Virtual visits should also have an effective system for booking and communicating follow-up appointments including informing clients when they can access virtual drop-in hours..Text and email appointment reminders are helpful when possible.

A sample appointment card is below:

Please book follow up appointment in _____ days / weeks with:

- ☐ Dr. ______________________________
- ☐ NP ______________________________
- ☐ RN ______________________________
- ☐ Counsellor ______________________________
- ☐ Peer support ______________________________

FIRST APPOINTMENT CHECKLIST

The order of the following steps for the first appointment depends on local preference and staffing (e.g., some clinics offer a brief counseling assessment before the MD/NP assessment). A first RAAM clinic visit assessment should address relevant psychosocial and medical/pharmacologic issues.

Step 1: Welcome client and begin efforts to build safe and positive rapport.

Step 2: Assess client for acute issues (e.g., withdrawal, acute intoxication, psychosis, or suicidality) and t riage accordingly.

Step 3: Provide and collect **client form** (see following page) if used.

Step 4: Conduct client assessment using **intake form**. Intake form can be completed by different members of the care team based on team composition and clinic flow.

Step 5: Review local EMR and Connecting Ontario for relevant background information, e.g., recent medications or ED visits.

Step 6: Assess vitals and UDT if appropriate (see **Clinical and Administrative Policies** for a **medical directive** for point-of-care urine testing). If appropriate, offer testing for HIV, liver function, etc.

Step 7: Provide appropriate psychosocial supports including counselling, referrals to community programs, and harm reduction education and supplies.

Step 8: Prescriber provides education and counselling on pharmacotherapy options if indicated, e.g., OAT, anti-craving medications, management of acute withdrawal/planning for withdrawal management, as well as medication prescriptions if indicated.

Step 9: Prescriber reviews/provides management of acute medical needs related to substance use (e.g., cellulitis).

Step 10: Arrange for follow-up with appropriate members of the care team and book next appointment if indicated.

INTAKE FORM[2,3]

INTAKE FORM

REASON FOR PRESENTING: ______________________________

____

CURRENT SUBSTANCE USE: ______________________________

Type: ______________________________

Frequency: ______________________________

Quantity: ______________________________

Mode: ______________________________

Last use: ______________________________

HISTORY OF SUBSTANCE USE/SUBSTANCE USE TREATMENTS: ______________________________

____

CURRENT GOALS:

☐ withdrawal support
☐ harm reduction
☐ abstinence
☐ mental health
☐ other:

OTHER PROVIDERS: ______________________________

____

MENTAL HEALTH HISTORY: ______________________________

____

FORMAL DIAGNOSIS MADE: ☐ Yes ☐ No

[2] Adapted from materials provided courtesy of the Northwestern Ontario Regional RAAM Steering Committee.
[3] Simple intake forms help ensure useful information is captured at first visit without being overly burdensome on the client.

SUICIDE RISK/ASSESSMENT: ______________________________

____

MEDICAL HISTORY: ______________________________

____

MEDICATIONS: ______________________________

____

ALLERGIES: ______________________________

____

SOCIAL SUPPORTS: ______________________________

____

CHILDREN AT HOME: ______________________________

____

BASIC NEEDS: ______________________________

____

LEGAL ISSUES: ______________________________

____

SAFETY ISSUES: ______________________________

____

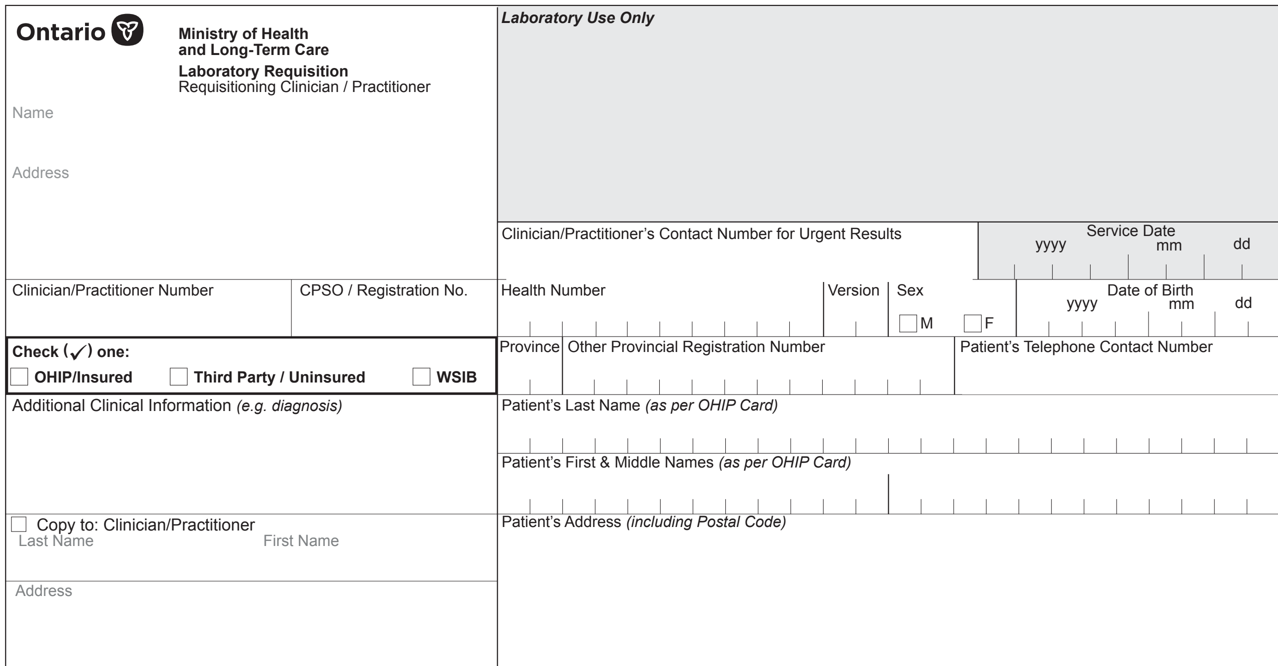
WORK SAFETY CONSIDERATIONS: ______________________________

____

TREATMENT PLAN: ______________________________

____

STANDARD INTAKE LAB REQUISITION



Ontario Ministry of Health and Long-Term Care
Laboratory Requisition
Requisitioning Clinician / Practitioner

Name

Address

Clinician/Practitioner Number	CPSO / Registration No.

Check (✓) one: ☐ **OHIP/Insured** ☐ **Third Party / Uninsured** ☐ **WSIB**

Additional Clinical Information *(e.g. diagnosis)*

☐ Copy to: Clinician/Practitioner
Last Name First Name

Address

Laboratory Use Only

Clinician/Practitioner's Contact Number for Urgent Results	Service Date yyyy mm dd

Health Number	Version	Sex ☐ M ☐ F	Date of Birth yyyy mm dd

Province	Other Provincial Registration Number	Patient's Telephone Contact Number

Patient's Last Name *(as per OHIP Card)*

Patient's First & Middle Names *(as per OHIP Card)*

Patient's Address *(including Postal Code)*

Note: Separate requisitions are required for cytology, histology / pathology, ColonCancerCheck FIT test, and tests performed by Public Health Laboratory

x	Biochemistry
X	Glucose ☐ Random ☐ Fasting
	HbA1C
X	Creatinine (eGFR)
	Uric Acid
	Sodium
	Potassium
X	ALT
X	Alk. Phosphatase
X	Bilirubin
	Albumin
	Lipid Assessment (includes Cholesterol, HDL-C, Triglycerides, calculated LDL-C & Chol/HDL-C ratio; individual lipid tests may be ordered in the "Other Tests" section of this form)
	Albumin / Creatinine Ratio, Urine
	Urinalysis (Chemical)
	Neonatal Bilirubin:
	Child's Age: days hours
	Clinician/Practitioner's tel. no.
	Patient's 24 hr telephone no.
	Therapeutic Drug Monitoring:
	Name of Drug #1
	Name of Drug #2
	Time Collected #1 hr. #2 hr.
	Time of Last Dose #1 hr. #2 hr.
	Time of Next Dose #1 hr. #2 hr.

I hereby certify the tests ordered are not for registered in or out patients of a hospital.

X

Clinician/Practitioner Signature Date

x	Hematology
X	CBC
	Prothrombin Time (INR)
	Immunology
	Pregnancy Test (Urine)
	Mononucleosis Screen
	Rubella
	Prenatal: ABO, RhD, Antibody Screen (titre and ident. if positive)
	Repeat Prenatal Antibodies
	Microbiology ID & Sensitivities (if warranted)
	Cervical
	Vaginal
	Vaginal / Rectal – Group B Strep
X	Chlamydia *(specify source)*: urine
X	GC *(specify source)*: urine
	Sputum
	Throat
	Wound *(specify source)*:
	Urine
	Stool Culture
	Stool Ova & Parasites
	Other Swabs / Pus *(specify source)*:

Specimen Collection

Time	Date

Laboratory Use Only

x	Viral Hepatitis *(check **one** only)*
	Acute Hepatitis
	Chronic Hepatitis
X	Immune Status / Previous Exposure *Specify*: ☒ Hepatitis A ☒ Hepatitis B ☒ Hepatitis C or order individual hepatitis tests in the "Other Tests" section below

Prostate Specific Antigen (PSA)

☐ Total PSA ☐ Free PSA

Specify one below:

☐ Insured – Meets OHIP eligibility criteria
☐ Uninsured – Screening: Patient responsible for payment

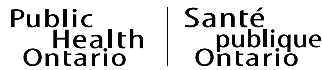
Vitamin D (25-Hydroxy)

☐ Insured - Meets OHIP eligibility criteria: osteopenia; osteoporosis; rickets; renal disease; malabsorption syndromes; medications affecting vitamin D metabolism
☐ Uninsured - Patient responsible for payment

Other Tests - one test per line
EKG
VDRL
HIV
urine for broad spectrum toxicology
urine BHCG

4422-84 (2019/05) © Queen's Printer for Ontario, 2019 7530-4581

HIV SEROLOGY LAB REQUISITION



For laboratory use only	
Date received (yyyy/mm/dd):	PHOL No.:

HIV Serology
HIV PCR Test Requisition

ALL Sections of this form must be completed at every visit

1- Submitter

Name
Address
City & Province
Postal Code

Submitter lab no. number (if applicable):

Clinician initial / Surname and OHIP / CPSO No.:

Telephone:	Fax:

cc Doctor / Qualified Health Care Provider Information

Name:	Telephone:
Lab / Clinic Name:	Fax: (###) ###-####
CPSO No.:	
Address:	Postal Code:

2 - Patient Information

Health Card No.:	Medical Record No.:
Date of Birth (yyyy/mm/dd):	Sex: ◯ M ◯ F ◯ TM* ◯ TF* *TF = transfemale (M to F); TM = transmale (F to M)
Last Name:	First Name:
Address:	
City:	Postal Code:
PHO study or program no. (if applicable):	

3 - Country of Birth:

4 - Race Ethnicity (check all that apply)

- ☐ White
- ☐ Black
- ☐ First Nations
- ☐ Métis
- ☐ Inuit
- ☐ South Asian (e.g. East Indian, Pakistani, Sri Lankan, Punjabi, Bangladeshi, Nepali)
- ☐ Southeast / East Asian (e.g. Filipino, Vietnamese, Cambodian, Thai, Indonesian, other Southeast Asian descent; Chinese, Korean, Japanese, Taiwanese descent)
- ☐ Arab / West Asian (e.g. Armenian, Egyptian, Iranian, Lebanese, Moroccan)
- ☐ Latin American (e.g. Mexican, Central / South American)
- ☐ Other, please specify:

5 - Risk Factors (check all that apply)

- ☐ Sex with women
- ☐ Sex with men
- ☐ Injection drug use
- ☐ Born in an HIV-endemic country (includes countries in sub-Saharan Africa and the Caribbean)
- ☐ Child of HIV+ mother
- ☐ Other, please specify:

Sex with a person who was known to be:

- ☐ HIV-positive
- ☐ Using injection drugs
- ☐ Born in an HIV-endemic country (includes countries in sub-Saharan Africa and the Caribbean)
- ☐ A bisexual male

6 - Specimen Details

Collection date of specimen (yyyy/mm/dd):

Type of specimen: ☐ Whole blood ☐ Dried blood spot (HIV PCR only) ☐ Serum ☐ ACD / EDTA ☐ Plasma

Tests requested: ☐ HIV1 / HIV2 ☐ HIV PCR (for infant diagnosis ≤18 months)

Comments:

7 - Reason for Test (check all that apply)

- ☐ Routine
- ☐ Known to be HIV positive (repeat test)
- ☐ Symptoms - acute seroconversion (e.g. flu-like illness, fever, rash)
- ☐ Symptoms - advanced disease / AIDS
- ☐ Sexual assault
- ☐ Visa / immigration requirement
- ☐ Prenatal
- ☐ Pre-exposure prophylaxis
- ☐ Post-exposure prophylaxis
- ☐ Infant diagnosis ≤18 months
- ☐ Self-test; result: ☐ POS ☐ NEG ☐ Invalid
- ☐ Other, please specify:

8 - Previous Test Information

Last test result:

- ☐ Negative
- ☐ Positive (in Ontario)
- ☐ Positive (outside Ontario)
- ☐ Unknown
- ☐ Indeterminate

Previous PHOL sample no. (if available):

CONFIDENTIAL WHEN COMPLETED
The personal health information is collected under the authority of the Personal Health Information Protection Act, s.36(1)(c)(iii) for the purpose of clinical laboratory testing. If you have questions about the collection of this personal health information please contact the PHO laboratory Manager of Customer Service at 416-235-6556 or toll free 1-877-604-4567.
Form No. F-SD-SCG-1001 (21/03/23).

CLIENT PAPERWORK

During the first visit, it is important that clients feel informed about what care they will receive through the RAAM clinic and what rights they will have as a service user. Clinicians will also use the first visit as an opportunity to collect information about the client's goals and reasons for attending RAAM. These form templates can be used to facilitate information exchange and can be customized to your unique setting.

Virtual help for substance use flyer

What to expect in the first visit handout

Client form

Client rights and responsibilities

Consent to service

Consent to obtain and release information

Consent and waiver for electronic communication

VIRTUAL HELP FOR SUBSTANCE USE[4]

Rapid Access Addiction Medicine (RAAM) Clinic DIGITAL FRONT DOOR

If accessing support for substance use in person is difficult, or if you'd just rather seek treatment virtually, our **RAAM Digital Front Door** allows you to access the same services online without having to come into the clinic in person.

Connect with experienced healthcare professionals by checking in during drop-in hours through **https://womenscollege.accessraam.ca/** using any device – phone, laptop, or tablet.

Available [days and times]

No referral required

WHO IS IT FOR?

People experiencing challenges with substance use who are looking to receive counseling, appropriate medications, and connections to community programs without a referral or pre-booked appointment.

WHO WILL YOU MEET?

Our care team includes [list roles, e.g., a peer support worker, addiction service worker, a nurse practitioner, and physicians]. You will meet a combination of team members, depending on your needs.

[4] Adapted from materials provided courtesy of Women's College Hospital.

WHAT TO EXPECT IN A FIRST APPOINTMENT[5]

YOU'VE ARRIVED!

Welcome to the RAAM clinic. Thank you for coming! Rapid access addiction medicine (RAAM) clinics are for people looking for help with their substance use.

You are not alone – there are more than 80 RAAM clinics all across Ontario.

WHAT HAPPENS NOW?

One of our team members will meet with you as quickly as they can to see how we can help you, which may involve counselling, medication, and/or connection to community programs.

WHO ARE WE?

Our team includes [list staff members - e.g., NPs, doctors, addiction service workers, peer support workers]. You will meet various team members, depending on your needs.

HOW LONG WILL I BE HERE?

We appreciate your patience while we are seeing other clients. Your first visit may take more than an hour, but follow-up visits will probably be shorter.

While you're waiting, please think about some of the things we may ask you about while you're here: your substance use history, previous treatments, your substance use goals (e.g., harm reduction vs. abstinence), medical and mental health conditions, medications, and allergies.

Please let the staff know if you're not feeling well so that we can help you.

WHAT KIND OF HELP WILL I GET?

We can help with all types of substance use (alcohol, opioids, cocaine/crack, meth, benzos, cannabis, and other drugs). Our goal at the first visit is to help get a plan started based on your priorities and goals. This might include help with withdrawal, medications to help you reduce cravings, referral to withdrawal management services and other community supports, and help with planning the next steps of your journey. Whatever plan you decide on today, we hope you'll come back to discuss how it's working and how we can help. Many people who have challenges with substances also have challenges with depression, anxiety, or other mental health issues. These are topics that we typically get into more in follow-up visits.

We are happy to provide naloxone kits and other harm-reduction supplies if that interests you.

NEXT STEPS

At the end of your appointment, stop by the check-out desk to book a follow-up appointment. You can also come back without an appointment during RAAM clinic drop-in hours.

RAAM CLINIC HOURS

In-person drop in: [Days and hours]
Virtual drop-in: [Days and hours]

---

[5] Adapted from materials provided courtesy of Women's College Hospital.

CLIENT FORM

Reason for coming in today:

____

____

____

____

Substances I would to discuss with my care team (check all that apply):

- ☐ alcohol
- ☐ benzodiazepines (e.g., alprazolam/Xanax, diazepam/Valium)
- ☐ cannabis
- ☐ opiates (e.g., fentanyl, hydromorphone/Dilaudid)
- ☐ stimulants (e.g., cocaine/crack, methamphetamines)
- ☐ other: ____

My current goals include (check all that apply):

- ☐ withdrawal support
- ☐ harm reduction
- ☐ abstinence
- ☐ mental health support
- ☐ housing help
- ☐ other: ____
- ☐ not sure yet

Current medications:

____

Are you in withdrawal right now? If yes, what from?

____

Is there someone with you today that you would like to bring into your appointment? If yes, please share name and relationship to you.

____

CLIENT RIGHTS AND RESPONSIBILITIES[6]

Client rights:

- To feel safe, respected, and treated with dignity.
- To be unharmed physically, emotionally, or psychologically by RAAM clinic staff.
- To receive appropriate support and attention.
- To actively participate in all aspects of care planning.
- To receive services even while under the influence of drugs or alcohol.
- To understand where and how to share any concerns about care, staff, and processes.

Client responsibilities:

- To respect others while on site.
- To help create and maintain a safe and respectful space for all clients and staff.
- To not use, sell, exchange, share, or pass substances to anyone while onsite.
- To respect the privacy of others onsite.
- To bring concerns or complaints to the attention of a clinic manager.

Signature

Date

[6] Adapted from materials provided courtesy of the Northwestern Ontario Regional RAAM Steering Committee.

CONSENT TO SERVICE[7]

Terms of Service

RAAM clinics are designed to provide timely access to care provided by a multidisciplinary team, which may include physicians, nurse practitioners, registered nurses, traditional healers, addiction counsellors, and peer support workers. The purpose of a team-based approach is to enhance the quality of care through a collaborative, holistic model of service delivery.

Confidentiality

All staff, students, and volunteers are bound by the policies of their respective agency and by the Personal Health Information Protection Act. Information about clients is entered into an information database. These systems are confidential, and access is limited to authorized personnel. Clinical data may be accessed for program evaluation or research purposes, accreditation review, or file audits.

Clinic staff may discuss aspects of your care that are relevant for service planning/support with one another. With your consent, RAAM staff may also discuss your care with other providers within the "circle of care," such as your primary care clinician. All staff follow the standards of their professional organizations and the laws regarding the use and sharing of personal health information.

In order for us to release or obtain information about you outside of RAAM clinic partners, we must first ask your permission to do so. This permission will be documented in writing and recorded in your clinical file. At any time, you may revoke the Consent to Obtain and Release Information, preferably in writing.

There are some limits to confidentiality, required by law, where information may be given without your consent. Limits to confidentiality include:

- Threat to harm self and/or others;
- Sharing of information with other staff/medical professionals in an emergency situation;
- Suspected child abuse or neglect;
- Impaired driving ability;
- Court subpoenas or court orders;
- Sharing of information with clinic staff/service providers who, by virtue of their job, responsibilities, need to know.

Appointments

Drop-in services are available; however, follow-up appointments will be scheduled as appropriate. We strongly encourage you to keep your scheduled appointments or to contact the clinic as soon as possible if you are unable to attend an appointment and wish to rebook. The RAAM clinic is intended to be a short-term service. Clients will be transitioned to a primary care provider, community clinic, or other care setting when and as appropriate.

[7] Adapted from materials provided courtesy of the Northwestern Ontario Regional RAAM Steering Committee.

Access to Records

It is standard professional practice to keep a record of clinical activities such as medical treatments or counseling notes. You have the right to access information about you that is kept in your client record (also known as your personal health information). If you request a copy of any part of your clinical record, you will be asked to sign a release of information. A fee may be charged for this service.

Complaints and Concerns

If you have any questions, concerns, or comments about any aspect of our service, any of the RAAM clinic staff or management team would be pleased to meet with you.

Quality Assurance

It is important for us to know what you think about our programs and services. We may ask you to tell us your thoughts or to complete a questionnaire about our services. Your feedback will be held in the strictest confidence.

Signature

I, ______________________________, understand this information and accept these Terms of Services.

______________________________ ______________

Signature: Date

Copy Given: ☐ Yes ☐ No

Please retain original on client record

CONSENT TO OBTAIN AND RELEASE INFORMATION[8]

The protection of your privacy and the delivery of high-quality care is our priority. In order to best serve you, a group of service providers, all committed to the protection of your privacy, are working together to support your decisions regarding your care. With your permission, we will share information with each other and with other agencies to support you in developing a plan of care that is designed to support your choices and decisions. The following agencies are part of a service system that is designed to support you in reaching your personal goals.

Agency name	**Permission to share personal health information** (initial below)	**Permission to share assessment, treatment, and case management information** (initial below)
1.		
2.		
3.		

There may be reasons to share your personal health information as well as assessment, treatment, and case management information with other agencies to support you in meeting your personal goals. If you are in agreement for the agencies and related programs named above to share this information, please indicate your authorization by initialing beside each relevant agency.

Having read and understood this form, I hereby authorize the identified agencies to release and request information to and from each other and to and from the RAAM clinic. I also understand that I can withdraw my consent in writing at any time and that I can restrict the nature and type of information shared.

Name

Signature

Date

[8] Adapted from materials provided courtesy of the Northwestern Ontario Regional RAAM Steering Committee.

CONSENT AND WAIVER FOR ELECTRONIC COMMUNICATION[9]

I understand and accept that there are significant risks associated with e-mail and text communications and video calls, including the following:

1. Increased risk of personal information being disclosed to/accessed by third parties.
    - Employers and online services may have a legal right to inspect and keep electronic communications that pass through their system.
    - Electronic communications can be forwarded, intercepted, circulated, stored, or even changed without the knowledge or permission of the RAAM clinic or the client.
    - Deleted or backup copies of electronic communications may exist on a computer system.
    - Electronic communications may be disclosed in accordance with a duty to report or a court order.
    - Videoconferencing services may be more open to interception than other forms of communication.
    - E-mail and text messages can more easily be misdirected, resulting in increased risk of being received by unintended and unknown recipients.
    - Someone may impersonate others over e-mail, and this impersonation may not be detected by the recipient.
2. Electronic communications can introduce malware into a computer system and potentially damage or disrupt the computer, networks, and security systems.
3. E-mail and text messages can be easier to falsify than handwritten or signed hard copies.

I understand and accept the following:

1. The RAAM clinic is not responsible for any costs related to text/e-mail correspondence.
2. Care provided through electronic communication cannot replace the need for physical examination or an in-person visit for some situations, and I understand the need to seek urgent care in an emergency department as necessary.
3. The RAAM clinic is not liable for breaches of confidentiality caused by a member of the RAAM staff or clinical team or any third party (i.e., anyone else who accesses my cell phone or computer).
4. I may withdraw my consent to communicate by e-mail, text, or video call at any time and must do so in writing.

I declare I have read, understood, and agree to the contents of this Consent and Waiver for Electronic Communication in its entirety. I agree that the RAAM clinic will not be liable for any breaches of confidentiality, whether caused by me, RAAM clinic employees, or a third party. By accepting these terms, I understand the risks and limitations of electronic communications, such as e-mail, text, and video calls. I waive and hold harmless the RAAM clinic from and against all claims, damages, losses, expenses, and costs, including reasonable legal fees relating to or arising from any information shared due to my use of the above mentioned electronic communications with the RAAM clinic.

[9] Adapted from materials provided courtesy of the Northwestern Ontario Regional RAAM Steering Committee.

I consent to exchanging personal health information by (please check which form(s) of communication apply):

☐ E-mail ☐ Text messaging ☐ Video calls

NOTE TO CLIENT: In order to communicate with you by text messaging and/or e-mail, we need to make sure you are aware of and consent to the privacy risks and other issues that arise when we communicate this way and to document your agreement.

- I understand that text messaging and/or e-mail is not appropriate for emergency or urgent situations.
- I understand that there is no guarantee that e-mails/texts will be checked in a timely manner, and anything that requires timely action is best communicated during my appointment or by calling the RAAM line.
- I understand that I am not able to access my provider outside of clinic hours and that I should contact emergency services if I require immediate assistance.
- I understand that text messaging and/or e-mail correspondence may be included in my file.
- I understand that the RAAM clinic will not forward my texts and/or e-mail without my consent to any third party except as authorized by law.
- I understand that the RAAM clinic is not liable for breaches of confidentiality caused by me or any third party (i.e., anyone else who accesses my cell phone or computer).
- I understand the risks and limitations associated with the communication of texts and/or e-mail between the RAAM clinic and me.

I declare I have read, understood, and agree to the contents of this Informed Consent for text messaging and/or e-mail in its entirety. By signing this form, I confirm that I understand the risks and limitations of text messaging and/or e-mail.

Client name	Date of birth
Signature	Date

Distribution: Copy to Client