Initiate Home Clinic Registration Form

Note: Clinics in which the providers only provide episodic care to their patients, should not register.

[Instructions](https://sharedhealthmb.ca/health-providers/digital-health/home-clinics/registration-form/) are available for completing each section. If you have any questions while completing this form, call (204) 926-6010, 1-866-926-6010 or email homeclinic@sharedhealthmb.ca

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| 1. **Home Clinic Information**
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| **Proposed Home Clinic Name:** |        |
| **Home Clinic Owned and Operated by:**  | [ ]  Regional Health Authority  | [ ]  Private | [ ]  Other *(specify)*  |
| Name of Medical Director of clinic:  |
| **Services offered:** *(select all that apply)* | [ ]  Primary Care  | [ ]  Walk-In  | [ ]  Specialty  |
| **Existing or new clinic:** | [ ]  Existing  | [ ]  New (Opening Date:      ) |
| **Provider patient panels:***(select all that apply)* | [ ]  Providers have existing panel or enrolment at clinic  | [ ]  Providers bringing panel or enrolment from previous clinic  | [ ]  Accepting new patients |
| **Participation in RHA Programs & Services:** *(select all that apply)* | [ ]  Family Doctor Finder [ ]  Other *(specify)*  | [ ]  My Health Team | ***Note: An RHA representative may reach out to discuss programs and services*** |
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| **Home Clinic’s Primary Location**  | **Unit:** |  | **Street Number:** |  | **Post Office Box:** *(if applicable)* |  |
| **Street Name:** |       |
| **City/Town** |       | **Postal Code:** |       |
| **Email:** |       |
| **Telephone Number:** |       | [ ]  Mobile [ ]  Work |
| **Mailing Address same as Primary Location:**  | [ ]  Yes  | [ ]  No (This address can be provided at a later date when completing the registration process in the Home Clinic Portal) |
| **Other Sites or locations associated to your clinic:** | \****Names of sites and addresses or community***           |
| 1. **Home Clinic’s Primary Contact -** single point of contact that will work closely with Digital Health’s Home Clinic team
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| **First and Last Name:**  |       |
| **Position/Title:**  |       |
| **Email:**  |       |
| **Telephone Number:**  |       | [ ]  Mobile [ ]  Work |

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| 1. **EMR Information**
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| **EMR Product Name:**  |       |
| **Using a Shared EMR:**  | [ ]  EMR is shared with other practices (e.g. single EMR database, regional shared instance)[ ]  EMR used solely by Home Clinic |
| 1. **Home Clinic’s Portal Users -** designate only two resources as users of the Home Clinic Portal (one as primary and one as back-up). If the Primary Contact listed will be a user, count this as one
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| **Primary Contact a Portal User:**  | [ ]  Yes  | **Digital Health network NTDWRHA** **User ID:** (if known) |       |
| **User** | **First and Last Name:**  |       |
| **Position/Title:**  |       |
| **Email:**  |       |
| **Telephone Number:**  |       | [ ]  Mobile [ ]  Work |
| **Digital Health network NTDWRHA User ID:** (if known) |       |
| **User** | **First & Last Name:**  |       |
| **Position/Title:**  |       |
| **Email:**  |       |
| **Telephone Number:**  |       | [ ]  Mobile [ ]  Work |
| **Digital Health network NTDWRHA User ID:** (if known) |       |

**Return the completed form via email to** homeclinic@sharedhealthmb.ca