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](mailto:homeclinic@sharedhealthmb.ca)

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. **Home Clinic Information** | | | | | | | | | | | |
| **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*** | | | |
|  | | | | | | | | | |
| **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 | | | | | | | | | | | |
| **First and Last Name:** | |  | | | | | | | | | |
| **Position/Title:** | |  | | | | | | | | | |
| **Email:** | |  | | | | | | | | | |
| **Telephone Number:** | |  | | | | | | | Mobile  Work | | |

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| 1. **EMR Information** | | | | | | |
| **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 | | | | | | |
| **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](mailto:homeclinic@sharedhealthmb.ca)