

Initiate Home Clinic Registration Form

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

[Instructions](#) 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

1. Home Clinic Information						
Proposed Home Clinic Name:						
Home Clinic Owned and Operated by:		<input type="checkbox"/> Regional Health Authority <input type="checkbox"/> Private <input type="checkbox"/> Other (<i>specify</i>)				
		Name of Medical Director of clinic:				
Services offered: <i>(select all that apply)</i>		<input type="checkbox"/> Primary Care <input type="checkbox"/> Walk-In <input type="checkbox"/> Specialty				
Existing or new clinic:		<input type="checkbox"/> Existing <input type="checkbox"/> New (Opening Date: _____)				
Provider patient panels: <i>(select all that apply)</i>		<input type="checkbox"/> Providers have existing panel or enrolment at clinic <input type="checkbox"/> Providers bringing panel or enrolment from previous clinic <input type="checkbox"/> Accepting new patients				
Participation in RHA Programs & Services: <i>(select all that apply)</i>		<input type="checkbox"/> Family Doctor Finder <input type="checkbox"/> My Health Team <input type="checkbox"/> Other (<i>specify</i>)			Note: An RHA representative may reach out to discuss programs and services	
Home Clinic's Primary Location	Unit:		Street Number:		Post Office Box: <i>(if applicable)</i>	
	Street Name:					
	City/Town				Postal Code:	
	Email:					
	Telephone Number:	<input type="checkbox"/> Mobile <input type="checkbox"/> Work				
Mailing Address same as Primary Location:		<input type="checkbox"/> Yes <input type="checkbox"/> 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				
2. 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:		<input type="checkbox"/> Mobile <input type="checkbox"/> Work				

3. EMR Information			
EMR Product Name:			
Using a Shared EMR:		<input type="checkbox"/> EMR is shared with other practices (e.g. single EMR database, regional shared instance) <input type="checkbox"/> EMR used solely by Home Clinic	
4. Home Clinic's Portal Users - designate only <u>two</u> 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:		<input type="checkbox"/> Yes	Digital Health network NTDWRHA User ID: (if known)
User	First and Last Name:		
	Position/Title:		
	Email:		
	Telephone Number:	<input type="checkbox"/> Mobile <input type="checkbox"/> Work	
	Digital Health network NTDWRHA User ID: (if known)		
User	First & Last Name:		
	Position/Title:		
	Email:		
	Telephone Number:	<input type="checkbox"/> Mobile <input type="checkbox"/> Work	
	Digital Health network NTDWRHA User ID: (if known)		

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