Thunder Bay Multicultural Association

Cathy Woodbeck, Executive Director

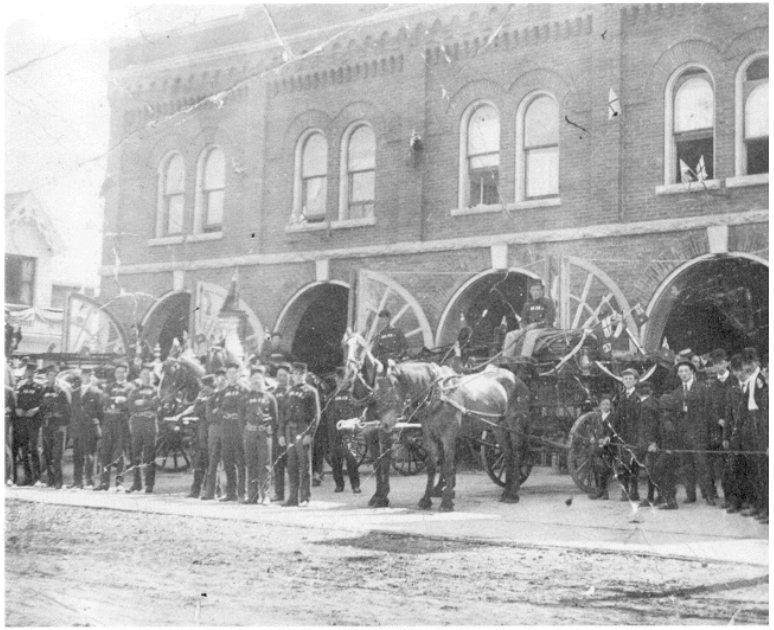
Thunder Bay Multicultural Association

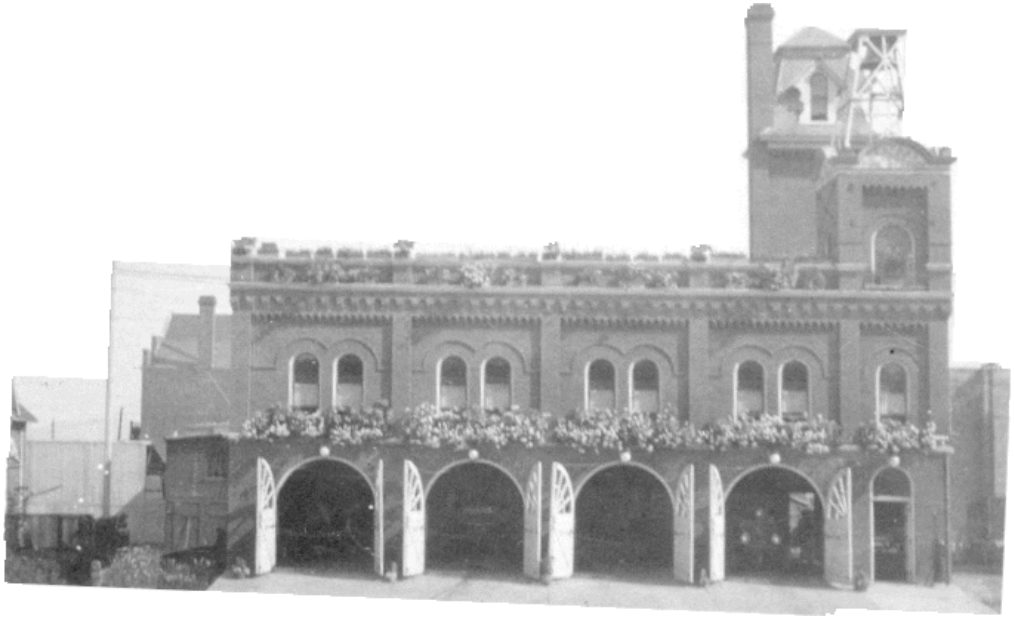
The Fabric of our Community

P2P Conference

Toronto 2015


Thunder Bay
THUNDER BAY
MILITARY MUSEUM
Thunder Bay
Charity Casino
COMMUNITY
SAFETY
ZONE
FINES
INCREASED






MULTICULTURAL ASSOCIATION

Programs and Funders

- Settlement Programs – Federal CIC
  - Information, Orientation and Referral (former Immigrant Settlement and Adaptation programs)
  - Language Instruction for Newcomers to Canada
    LINC classes, LINC assessment with CLBA and CLBLA etc. for all of Northern Ontario
  - Community Connections
    mentorship programs formerly HOST program, professional mentorship and youth groups

Local Immigration Partnership

Provincial Programs – MCIIT Ontario

Newcomer settlement program and Language Interpreter Service

Interpreter Service – providing interpretation and translation

We have a toll free telephone number, website, Face Time, Skype and email access for service to the region as well as a satellite office in Kenora to serve the western part of our catchment area. We have 36 contact points in the region.

Regional Partnerships and Technology

- * large distances and remote communities
- * partners spread across the region we serve
- * technology is the key to connecting
- * Immigration Partnership made up of 36 municipalities and a variety of partners within those 36 communities. Meet via technology.
- * web ex, go to meeting
- * discussion boards
- * google docs
- * drop box

Successful Partnership Project with Northern Ontario School of Medicine

- Met as an advisory group with settlement agency, medical clinics, NOSM, refugee groups, dentists, health unit and Local Health Integration Network.
- Issues identified, project proposed and Medical students took the initiative with the Thunder Bay Multicultural Association as a partner. Refugees and sponsorship groups evaluated and commented along the way.

HEALTH
PASSPORT

First Name: _____

Last Name: _____

I like to be called: _____

Please return this passport to me before I leave.

HEALTH
PASSPORT

ATTENTION HEALTH CARE PROVIDER:
This passport has important information so you can better support me when I visit/stay in your clinic or hospital.

This information is confidential.

If you would like to photocopy the information to keep it with my record, please ask my permission.

Please add important information about my health to keep this record up to date.

The Health Passport is a project led by students of the Global Health Interest Group at the Northern Ontario School of Medicine. For more information, contact the NOSM Student Society, nosmss@nosm.ca.

Thank you for support from:

Northern Ontario School of Medicine
École de médecine du Nord de l'Ontario

Northern Ontario School of Medicine Student Society

Thunder Bay Multicultural Association
The Fabric of our Community

ACS Photography Consulting Design

RAINBOW PRINTERS LTD.
GREENPRINT TECHNOLOGY

GENERAL INFORMATION

Paste Photo Here

Given names: _____

Last names: _____

I like to be called: _____

Sex: ☐ Female ☐ Male

Date of birth: _____ Blood type: _____

Country of origin: _____

Languages preferred: _____

Able to speak: _____

I require an interpretor/translator: ☐ Yes ☐ No

If yes, how do we contact them?

_____

Thunder Bay Multicultural Association 24h Interpreter Service 1-888-831-1144

Special needs:

MY ADDRESS

Telephone _____

Email _____

Street _____ Apt _____

City _____ Province _____

Country _____ Postal Code _____

MY ADDRESS (use this if you move or have a second address)

Street _____ Apt _____

City _____ Province _____

Country _____ Postal Code _____

EMERGENCY CONTACTS

If I am in an emergency please contact:

1. Name:_____
Relationship:_____
Phone 1:_____Phone 2:_____

2. Name:_____
Relationship:_____
Phone 1:_____Phone 2:_____

3. Name:_____
Relationship:_____
Phone 1:_____Phone 2:_____

MEDICAL INSURANCE

☐ OHIP Number: _____

☐ Trillium

☐ Interim Federal Health Program

☐ Ontario Drug Benefit program (ODB)

Persons receiving Ontario Works, ODSP, Trillium, or over 65 are eligible for ODB.

☐ Other

Name of Company/Organization: _____

Phone: _____ Fax: _____

Policy Number: _____

☐ Other

Name of Company/Organization: _____

Phone: _____ Fax: _____

Policy Number: _____

ALLERGIES AND SENSITIVITIES

Do you wear a medical alert bracelet? ☐ Yes ☐ No

Do you carry an Epi-Pen? ☐ Yes ☐ No

Do you have any allergies to...

☐ Medications

☐ Food

☐ Latex

☐ Anaesthesia

☐ Other substances

Please name the substance(s) you are allergic to and describe the reaction:

Name	Reaction

MEDICAL CONDITIONS

I have been diagnosed with the following conditions...

☐ Active Tuberculosis (TB), Date: _____

☐ Alzheimer's/other dementia

☐ Asthma

☐ Cardiovascular Conditions:

- ☐ Atrial Fibrillation
- ☐ CHF
- ☐ DVT/PE
- ☐ High Blood Pressure
- ☐ Previous MI
- ☐ Stroke

☐ Chronic Renal Insufficiency

☐ COPD

☐ Diabetes

☐ Epilepsy

☐ G-6-PD deficiency*

*If yes, I will become sick with hemolytic anemia and may develop jaundice if given aspirin, nitrofurantoin, antimalarial drugs, or fava beans.

☐ Hepatitis C

☐ HIV/AIDS

☐ Other medical conditions, list:

Date of onset	Diagnosis/Condition

SURGERY

Have you had any surgeries? ☐ Yes ☐ No

Have you had any reactions to anaesthetic? ☐ Yes ☐ No

☐ Appendix Removal, Date: _____

☐ Caesarean Section, Date: _____

☐ Gallbladder, Date: _____

☐ Thyroid Surgery, Date: _____

☐ Tonsil Removal, Date: _____

☐ Others: _____

MENTAL HEALTH

Do you have, or have you had in the past, any mental health conditions? ☐ Yes ☐ No

☐ Anxiety ☐ Bipolar Disorder ☐ Depression

☐ Schizophrenia ☐ Substance Abuse

☐ Other: _____

_____

OBSTETRIC/GYNECOLOGY HISTORY (Women Only)

Age of menarche: _____

Menopause: age at symptom onset: _____

age at final menses: _____

G (pregnancy): _____

T (term deliveries): _____

P (preterm deliveries): _____

A (abortions/miscarriages): _____

L (living children): _____

Have you had an abnormal PAP or gynecological disease or cancer?

☐ Yes ☐ No

Details: _____

_____

FAMILY MEDICAL HISTORY

Do you know if your parents, sisters and brothers, or children have any illnesses or diseases? ☐ Yes ☐ No

If yes, list:

Relationship	Illness/Disease	Comments (i.e. age of onset, severity etc.)

If applicable, do you know at what age your grandparents and/or parents died, and what was the cause of death?

Parents: _____

_____

Grandparents: _____

_____

MEDICATIONS

Do you use any prescription medications? ☐ Yes ☐ No

Name	Dose	Date started	Discontinued

Any additional medications can be recorded in "Notes" on pg. 12.

Do you use any...

Vitamins? ☐ Yes ☐ No

Details: _____

_____

Over the counter medications? ☐ Yes ☐ No

Details: _____

_____

Herbal or traditional medicines? ☐ Yes ☐ No

Details: _____

_____

SOCIAL HISTORY

Who do you currently live with? _____

_____

Do you use alcohol? ☐ Yes ☐ No

If yes, how much and how often? _____

Do you smoke cigarettes? ☐ Yes ☐ No

If yes, how many per day? _____

In what year did you start smoking? _____

What is the highest level of education you have obtained?

☐ None ☐ Primary

☐ Secondary ☐ Technical

☐ College ☐ University

☐ Other:

_____

_____

_____

Do you work outside the home?

☐ Yes, where? _____

☐ No, is there a particular reason why not? _____

_____

What culture or ethnicity do you identify with? _____

_____

Are there specific religious/cultural needs that impact how you would like to receive health care? _____

_____

_____

IMMUNIZATION RECORD

Keep a copy of your immunization record in the back pocket of this health passport, if available.

Common Vaccinations:

Name	Date(s)	Comments (reactions, side effects)
Polio		
Diptheria		
Tetanus		
Pertussis		
Hemophilus influenza type b (Hib)		
Meningitis		
Varicella		
Measles		
Mumps		
Rubella		
Hepatitis A		
Hepatitis B		
Typhoid		
Tuberculosis		
Human Papillomavirus (HPV)		
Seasonal Influenza (Flu shot)		

Have you received any other vaccinations?

Name	Date	Comments

RESIDENCY/TRAVEL HISTORY

Where were you born? _____

When did you immigrate to Canada? _____

Where have you lived and/or travelled to in the past?

Date, Duration	Location (Country, Cities)	Comments*

*Can include details about accommodation (i.e. house, adobe hut, tent, refugee camp, etc.) or local exposures that may be relevant.

HEALTH CARE PROVIDERS

DOCTOR/NURSE PRACTITIONER/USUAL WALK-IN CLINIC

Name: _____

Location: _____

Phone: _____ Fax: _____

SPECIALIST DOCTOR

Name: _____

Location: _____

Phone: _____ Fax: _____

PHARMACY

Name: _____

Location: _____

Phone: _____ Fax: _____

DENTIST

Name: _____

Location: _____

Phone: _____ Fax: _____

COUNSELLOR

Name: _____

Location: _____

Phone: _____ Fax: _____

COMPLEMENTARY MEDICINE

Other providers, including spiritual/traditional/alternative medicine:

Name: _____

Location: _____

Phone: _____ Fax: _____

OTHER HEALTH CARE PROVIDER

Name: _____

Location: _____

Phone: _____ Fax: _____

NOTES

Include date of visit/observation

Use this pocket to keep a copy of your immunization record and updated medication list.

Contact information

Cathy Woodbeck
TBMA
(807) 345-0551
cathyw@thunderbay.org