Vancouver CoastalHealth
Promoting wellness. Ensuring care.

PARIS
PRIMARY ACCESS
Regional Information System

SHOP BY PHONE REGISTRATION

Name:		**PARIS ID:**
DOB:	**Age:**	**PHN:**
Gender:		**Phone:**
Home Address:		

Assessment Start Date: **Assessment End Date:** **Carried Out By:**

Support Information

1. How did you hear about the program?

☐ VCH Internal ☐ Friend/Neighbour ☐ Relative ☐ Safeway ☐ Other

2. Referral Reason

☐ Frail ☐ Chronic Diseases ☐ Mental Health ☐ Paraplegic/Quadriplegic ☐ Cancer Treatment
☐ Post Acute Care ☐ Other

Involved Staff

Staff	Team Detail	Allocation Type	Allocation Status

External Agencies/Other Professionals

Organization	Contact	Telephone	Valid From	Valid To

Service Information

Store: ☐ Tyne ☐ Broadway ☐ Oakridge ☐ Kitsilano

Service Frequency at time of Referral:

☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ As Needed

Casenotes

Note: Once downtime information from this form has been entered in PARIS, shred this working sheet.

-- End of Report --