HEALTH SERVICE PROVIDER REPORTS RECIPIENT FORM

For health service providers who are uploading assessments to the Integrated Assessment Record (IAR)

This electronic form is to be used for identifying *recipients* for each common assessment standardized reports generated by the IAR. Please fill out a form for each type of common assessment you have completely implemented (eg. OCAN or interRAI CHA).

This form is also to be used to update changes to the name and email address of your report recipients or change of name or details to your organization.

Sections A and G are mandatory. The other sections of this form are relevant when your organization needs to:

1. Add a reports recipient(s) – complete Section B
2. Modify information about an existing recipient(s) – (name, title or email address) – complete Section C
3. Modify information about an existing organization – complete Section D
4. Remove a reports recipient or discontinue receiving reports – complete Section E
5. Reset password – complete Section F

SECTION A: MANDATORY INFORMATION

What assessment will you be uploading?	☐ interRAI CHA ☐ Ontario Common Assessment of Need (OCAN) ☐ Both
Organization Name	
Org ID/ MIS ID/ Master ID	
IAR End User Internet Protocol (IP) Address	
Action requested – Choose from B-F below	
Date Action requested (dd/mm/yyyy)	
Check this box if you wish to receive reports in French as well	☐

SECTION B: ADD REPORT RECIPIENT(S)

Add Recipient	Information
Report Recipient 1 – First Name	
Report Recipient 1 – Last Name	
Report Recipient 1 – Title/ Position	
Report Recipient 1 – Email Address	
Report Recipient 2 – First Name	
Report Recipient 2 – Last Name	
Report Recipient 2 – Title/ Position	
Report Recipient 2 – Email Address	
Please note if additional staff require access, please attach a word document and include, first name, last name, position and email address for each additional individual.	

SECTION C: CHANGE REPORT RECIPIENT(S) INFORMATION

Change Recipient	Current Information	New Information
Report Recipient 1 – First Name		
Report Recipient 1 – Last Name		
Report Recipient 1 – Title/ Position		
Report Recipient 1 – Email Address		
Account Information to be changed on or before (dd/mm/yyyy)		
Reason for change (if a replacement, fill out section E)		
Report Recipient 2 – First Name		

Change Recipient	Current Information	New Information
Report Recipient 2 – Last Name		
Report Recipient 2 – Title/ Position		
Report Recipient 2 – Email Address		
Account Information to be changed on or before (dd/mm/yyyy)		
Reason for change (if a replacement, fill out section E)		

SECTION D: CHANGE ORGANIZATION INFORMATION

Change Organization	Current Information	New Information
Organization Name		
Org ID/ MIS ID/ Master ID		
Organization Information to be changed on or before (dd/mm/yyyy)		
Reason for change		

SECTION E: REMOVE REPORT RECIPIENT(S)

Remove Recipient	Information
Report Recipient 1 – First Name	
Report Recipient 1 – Last Name	
Report Recipient 1 – Email Address	

Remove Recipient	**Information**
Account to be removed on or before (dd/mm/yyyy)	
Special Instructions	
Report Recipient 2 – First Name	
Report Recipient 2 – Last Name	
Report Recipient 2 – Email Address	
Account to be removed on or before (dd/mm/yyyy)	
Special Instructions	

SECTION F: RESET PASSWORD

Reset Password	**Information**
Report Recipient 1 – First Name	
Report Recipient 1 – Last Name	
Report Recipient 1 – Email Address	
Report Recipient 2 – First Name	
Report Recipient 2 – Last Name	
Report Recipient 2 – Email Address	

SECTION G: AUTHORIZATION

The authorizer for the organization must authorize the actions requested above by signing in the section below. The designated reports recipients have received privacy training and are aware of this organization's obligations as a Health Information Custodian and will not use or share the information in these reports to attempt to re-identify individuals.

Authorizer	Details
First Name	
Last Name	
Email Address	
Phone Number	
Signature	

For Internal Use Only	Details
Support Centre Ticket Number	
Date when DSA takes effect or was withdrawn (dd/mm/yyyy)	
Authorizer Verified	☐
Request Completion Date in IAR (dd/mm/yyyy)	
Request Completed By	
HSP is entitled to receive reports	☐
Notes	

Email the completed and signed form to IAR_Submissions@ontariohealth.ca. If you have any questions, please contact us by visiting https://www.ontariohealth.ca/providing-health-care/clinical-resources-education/community-care-resources-support.