



Executive
Council

*A certified copy of an Order in Council dated
June 22, 2006.*

2006-286

The Governor in Council on the report and recommendation of the Minister of Justice and the Minister of Health dated June 21, 2006, and pursuant to Section 15 of Chapter 109 of the Revised Statutes of Nova Scotia, 1989, the *Court Houses and Lockup Houses Act*, and Section 95 of Chapter 37 of the Acts of 2005, the *Correctional Services Act*, is pleased, effective on and after July 1, 2006,

(a) to repeal the *Sharing of Health Information Regulations*, N.S. Reg. 151/2001, made by the Governor in Council by Order in Council 2001-588 dated December 14, 2001; and

(b) to make and approve of new regulations respecting the sharing of health information as set forth in Schedule "A" attached to and forming part of the report and recommendation.

Certified to be a true copy

Paul LaFleche

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Paul LaFleche
Clerk of the Executive Council

Approved by Order in Council
.....2006-286..... dated
.....June 22, 2006.....
Paul LaFleche
.....
Paul LaFleche
Clerk of the Executive Council

Schedule "A"

In the Matter of Section 95 of Chapter 37 of the Acts of 2005,
the *Correctional Services Act*

- and -

In the Matter of the *Sharing of Health Information Regulations*
made by the Minister of Justice and the Minister of Health
pursuant to Section 95 of the *Correctional Services Act*

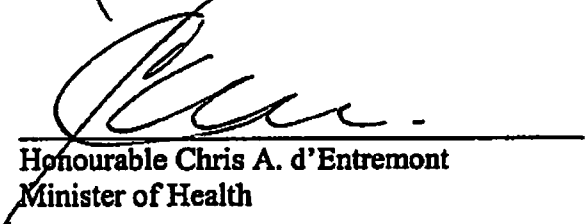
Order

We, Murray K. Scott, M.B., Minister of Justice for the Province of Nova Scotia, and
Chris A. d'Entremont, Minister of Health for the Province of Nova Scotia, pursuant to
Section 95 of Chapter 37 of the Acts of 2005, the *Correctional Services Act*, hereby make
regulations respecting the sharing of health information in the form set forth in the
attached.

This order is effective on and after July 1, 2006, and approval by the Governor in
Council.

Made at Halifax, in the Halifax Regional Municipality, Nova Scotia, on
June 21, 2006.


Honourable Murray K. Scott, M.B.
Minister of Justice


Honourable Chris A. d'Entremont
Minister of Health

Health Information Transfer Form

Pursuant to 95(1) (b) of the Correctional Services Act, sharing health information is necessary to ensure safety and continuity of care of a person in custody.

SECTION A MUST BE COMPLETED BY

- a) if the transfer originates at a facility or hospital, a representative of the facility or hospital;
- b) if the transfer does not originate at a facility or hospital, the transferring officer.

Name of person in custody: _____
Health card number (if known): _____ Date of birth: _____
Next of kin: _____ Telephone number: _____

SECTION B MUST BE COMPLETED BY THE TRANSFERRING OFFICER.

Conditions requiring ongoing attention:

- aggression towards others potential for self harm health issues

Statement of health status as observed by officer or reported by person in custody:

Assessed and/or treated by health care provider: yes no
(If yes health care must complete section D.)

Reasons for arrest _____

Name: _____ Signature: _____
Designation: _____ Phone#: _____

SECTION C MUST BE COMPLETED BY A REPRESENTATIVE OF A FACILITY OR HOSPITAL.

(applies if the transfer originates at a facility or hospital)

Conditions requiring ongoing attention:

- aggression towards others potential for self harm
 epilepsy high blood pressure alcohol/drug seizures heart problems
 diabetes suicidal thoughts Contact lenses other prosthesis
 breathing problems orthodontic appliances
 infectious disease (if required, please attach list of additional precautions for client, escorting and facility staff)

Medications (if known)

Medication	Dose	Frequency	Time last administered

Medications transferred with person in custody? Yes No

Known allergies: _____

Upcoming appointments (if known): _____

Name: _____ Signature: _____
Designation: _____ Phone#: _____

SECTION D MUST BE COMPLETED HEALTH CARE PROVIDER.

(applies if the person in custody being transferred receives care or treatment from a health care provider)

Principal/provisional diagnosis (physician only): _____

Treatment provided: _____

Present status and direction for continuity of care: _____

Name: _____ Signature: _____
Designation: _____ Phone #: _____

The reverse of this form must be completed each time a transferring officer, facility, hospital or health care provider accepts responsibility for the care of the person in custody being transferred, for example: 1) between a lock up and a police officer/sheriff;
2) between a correctional facility and a hospital.
All forms must accompany the person. Where applicable, attach this form to the warrant.

RECEIVING FACILITY/HOSPITAL

Date of arrival: DD/ MM/ YYYY

Time of arrival: _____

Signature - Receiving Facility/Hospital

RECEIVING FACILITY/HOSPITAL

Date of arrival: DD/ MM/ YYYY

Time of arrival: _____

Signature - Receiving Facility/Hospital

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