Grand Bend Area
Community Health Centre
Every One Matters.

Dear Patient,

You have asked to obtain a Family Physician at Grand Bend Area Community Health Centre. We wish we could accommodate all who live here, but unfortunately budget constraints do not make that possible at this time.

We have set priorities to ensure that those in the most need have a Family Doctor. As a result, first come is not necessarily first served. Please fill out an application. A physician will see how it fits into the priorities. You will be notified if we are able to provide you with a Family Doctor.

In the meantime, continue to see your current physician if you can.

Should you need services in the meantime and are unable to see your current physician; you may phone us for an appointment. Staff at GBA CHC will assess your condition and offer the appropriate care or advice. Response is based on your condition and on the availability of providers.

Sincerely,

Heather Klopp
Director of Health Support Services
Grand Bend Area Community Health Centre

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Request for Family Physician

Name ______________________ Date of Birth ______________________
Address ____
____

______________ ______________ ______________
Home Phone | Mobile Phone | Email

Health Card Number ______________________ Version Code __________

Family members also making application

Name	Date of Birth	Sex	Health Card Number

Do you presently have a family doctor? ☐ Yes ☐ No
If yes, doctor's name and location. ______________________
If no, who was your last family doctor and when did you last see him or her?
____

Reason for Request or Special Needs (**also please note if you have a terminal illness)
____
____

Current Medical Problems (Check appropriate diagnosis)

☐ Diabetes
☐ Heart Disease / Stroke
☐ Kidney Disease
☐ Dementia / Alzheimer's
☐ Organ Transplant
☐ Cancer (receiving treatment
☐ COPD / Asthma / Emphysema
☐ Taking Coumadin / Warfarin
☐ Disabled (reason ___________)
☐ Other ______________________
☐ High Blood Pressure
☐ High Cholesterol
☐ Thyroid Disorder
☐ Pregnancy

Medications:
____
____
____

If accepted as a patient I will arrange, at my own expense, to have my previous medical records forwarded to Grand Bend Area Community Health Centre.

Signature ______________________ Date ______________

For office use only			
Intake visit date			
Primary Physician		Nurse Practitioner	