Grand Bend Area
Community Health Centre

July 26, 2021

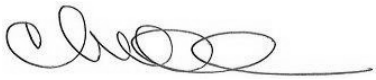
Dear Applicant:

Thank you for your interest in becoming a primary care patient of the Grand Bend Area Community Health Centre (GBACHC).

Please complete the attached *Request for Physician* application form. **Note – submitting this form does not guarantee admission at this time.** The GBACHC currently has an admission waiting list to which your application will be added. Your admission will be based on a need assessment, your health and life circumstances, and the order in which the *Request for Physician* application form is received. In the meantime, if you have a family physician, you are encouraged to continue seeing them.

While you wait to be admitted as a primary care patient, the GBACHC system navigator will be in contact with you to share information about GBACHC programs that may assist you in meeting your well-being goals.

Best regards,



Chris Harris
Chief Executive Officer

Grand Bend Area
Community Health Centre

Request for Family Physician

Name: _____ Date of Birth: _____

Street Name and Number: _____ PO Box: _____

City: _____ Prov.: _____ Postal Code: _____

Home Phone: _____ Cell: _____ Business: _____

Email Address: _____

Health Card Number: _____ Version Code: _____

Do you presently have a family physician: ☐ Yes ☐ No

If yes, physician's name and practice location: _____

If no, last physician's name and last seen date: _____

Reason for requesting a family physician and your specific health care needs. (Please note if you have a terminal illness.): _____

_____

Current Medical Conditions (Check all that apply)

☐ Diabetes	☐ Thyroid Disorder	☐ High Blood Pressure
☐ Cancer	☐ Heart Disease/Stroke	☐ COPD/Asthma/Emphysema
☐ Kidney Disease	☐ High Cholesterol	☐ Dementia/Alzheimer's
☐ Pregnancy	☐ Organ Transplant	☐ Taking Coumadin/Warfarin
☐ Disability: _____	☐ Other: _____	

List of Medications: _____

Family members also applying	Date of Birth	Gender	Health Card No.

If admitted as a primary care patient, I will arrange at my expense to have my medical records sent to the Grand Bend Area Community Health Centre.

Signature: _____ Date: _____

Office Use Only Intake Visit Date: _____

Primary Physician: _____ Nurse Practitioner: _____