



Grand Bend Area Community Health Centre

P.O. Box 1269, 69 Main St. E., Grand Bend, ON N0M 1T0 Phone: 519-238-2362 Fax: 519-238-6478
www.gbachc.ca

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 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
Health Services Coordinator
Grand Bend Area CHC



REQUEST for FAMILY PHYSICIAN

Name: _____ Date of Birth: _____

Address: _____

Phone:(home)_____ (business)_____

Health Card Number: _____ Version Code _____

Family Members under 16years old also making application:	Date of Birth	M/F	Health Card #
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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 do 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)
- Pregnancy
- COPD/Asthma/Emphysema
- Disabled (reason:_____)
- Taking Coumadin/ Warfarin
- High Blood Pressure
- High Cholesterol
- Asthma/COPD
- Thyroid disorder
- Other: _____

Medications:

If accepted as a Patient I will arrange, at my expense, to have my previous medical records forwarded to Grand Bend Area CHC.

Signature: _____ Date: _____

Office Use Only: Intake visit date: _____ Primary Physician: _____	Nurse Practitioner: _____
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