



Client Application For Primary Care Services

WEST LAMBTON COMMUNITY HEALTH CENTRE – SARNIA
429 Exmouth Street, Suite 100, Sarnia, Ontario, N7T 5P1, Phone: 519-344-3017

Name: _____ Date of Birth: ____/____/____
First Last Day / Month / Year

Address: _____ Postal Code: _____

Telephone #s: Home _____ Work _____ Other _____

Do you have a valid Ontario Health Card? Yes No

Are you a permanent resident of the West Lambton Community Health Centre catchment area?
 (South of Lake Huron, North of Whitebread Line/Kent Line, West of Mandaumin Road, & East of Lake Huron)
 (see map on reverse side of "Dear Applicant" letter) Yes No

Did a particular community agency refer you to the West Lambton Community Health Centre?
 If yes, which one, (i.e. Canadian Mental Health, Bluewater Health): _____
 and who is/are your contact person(s) with this agency ? _____

Is there a Consent Form from the referring agency attached? Yes No

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 this Doctor: _____

Research has shown that certain groups of people in the Lambton-Sarnia area have difficulties obtaining Primary Health Care. Therefore, the following populations will have priority with regards to acceptance:
(please check all that apply to you)

Senior (age 65 & older) Youth (ages 16-24) Mental Illness (moderate)
 Low Income Person with a disability None

Which types of transportation do you use most often:
 (you may check more than one)

Walking Bicycle Bus Taxi Friend with a car Family with a car Your own car

Please explain the best way for us to contact you: _____

Please complete the back of the form...

We also recognize that there are some medical conditions that may need to take priority on the waiting list. To allow us to prioritize applications and select the most appropriate provider, please complete the following:

Examples of Medical Conditions: (Please check all that apply)

- Asthma or Lung Disease (COPD)
- Heart Disease (Heart Attack, Angina)
- High Blood Pressure
- Diabetes
- Stroke
- Cancer – What Kind _____
- Anxiety/Panic Disorder
- Depression
- Other Mental Health Disorder: (please explain) _____
- Addiction(s): (please explain) _____
- Other serious medical or special circumstances not listed above (please explain) _____

Please list all medications you are currently taking: (including non-prescription medications)

Medication Name	Prescription? Yes or No	If prescription medication, who provides the prescription?

Which pharmacy do you use to have your prescriptions filled? _____

I understand that all personal health information on this form is confidential and will be treated according to the West Lambton Community Health Centre’s Privacy Policy, which is available to me on request.

I understand and consent to the use of my personal health information on this form by the West Lambton Community Health Centre’s Wait List Management Committee to determine my eligibility for primary care at the Centre.

If my application is accepted, I agree to have my medical records transferred to the West Lambton Community Health Centre. I understand the health care system is under great pressure and “double-doctoring” is not acceptable

I understand that if I have given false information, I will be excluded from being accepted into this practice. I hereby declare that the above information is up-to-date and correct.

Please Print Name (first / last)

Signature

Date (Day / Month / Year)