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Central Lambton Family Health Team
4130 Glenview Road, Unit 3
PETROLIA, Ontario N0N 1R0
Telephone 519-882-2500 Fax 519-882-4321

Contact and Medical Information Sheet

Surname _____ Given Name(s) _____

Date of Birth (mm-dd-yyyy) _____ Age _____ Gender (circle): Male Female Another Gender

Addresss: Number and Street _____ Apt Number _____

City _____ Postal code _____ Main Phone Number _____ Type (ie. cell) _____

Alternate Contact (ie. Cell #) _____ Type (ie. work, cell) _____ Health Card # and Version Code _____ Expiry Date _____

MEDICAL INFORMATION

Y	N	Diabetes: Type 1 Type 2	Y	N	Irritable Bowel Syndrome
Y	N	High Blood Pressure	Y	N	Heartburn, Indigestion, GERD
Y	N	High Cholesterol	Y	N	Crohn's Disease, Colitis
Y	N	Chest Pain, Angina	Y	N	Chronic Headaches
Y	N	Heart Failure	Y	N	Thyroid Disease: Hypothyroidism Hypertension
Y	N	Heart Attach, when	Y	N	Lupus
Y	N	Emphysema	Y	N	Kidney Disease
Y	N	Asthma	Y	N	Hernia
Y	N	Problem with ears, eyes, nose	Y	N	Urinary/Bowel Incontinence Ostomy Colostomy
Y	N	Arthritis, joint pain: knees hips ankles wrist hands back other:	Y	N	Have you ever had: Blood Clot, Deep Vein, Thrombosis, Pulmonary Embolism
Y	N	Chronic Back Pain	Y	N	Fibromyalgia
Y	N	Anemia	Y	N	Skin Condition
Y	N	Sleep Apnea	Y	N	COPD
Y	N	Cancer	Y	N	Stroke
Y	N	Mental health issues: Anxiety Depression Panic attacks Bipolar Psychosis Schizophrenia PTSD Other	Y	N	Other
			Y	N	Drug Allergies: list and type of reaction (rash, nausea, anaphylaxis)

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MEDICATIONS

Name	Dose	Frequency

PAST SURGERIES	DATE

FAMILY HISTORY OF SIGNIFICANT MEDICAL ISSUES	RELATION
EXAMPLE ***diabetes***	***father***

Patient Declaration

Due to the current family doctor shortage, patients without a current family doctor within Sarnia Lambton will be given a priority. Please check the box that must closely applies to you:

- ☐ My previous family physician has retired or moved.
- ☐ My previous family physician is still practicing but no longer provides my care.
- ☐ Until now, I have no had or felt the need to have a family physician
- ☐ I have relocated to Sarnia-Lambton and do not have a family physician in the community
- ☐ Other: _____

Name of previous/current family physician: _____

Date late seen: _____ Location: _____

PLEASE NOTE:

- Completition of this form does not guarantee entrance into our practice.
- **Central Lamtbon Family Health Team will maintain a strict narcotic prescription policy in order to minimize the potential for abuse. Narcotics will only be prescribed for legitimate pain control purposes. Extended/prolonged narcotic prescription abuse will be warned and subject to termination of the patient-physician relationship.**

Please be sure this form is fully completed. Please fill out a separate form for each family member and return all forms together.

By signing below, I acknowledge I have read and understood all policies and procedures, as well as answered all questions truthfully. If responses on this form as intentionally incorrect, the patient-physician relationship may be terminated.

_____ _____

Signature Date

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Central Lambton Family Health Team

Consent for Communication with Office

This form allows you specify your communication preferences. It also allows you to name a person to communicate with the CLFHT on your behalf. Your medical information may only be relayed to you or your authorized contacts as indicated below.

Section A. Your Information

Name :_____

Date of Birth: _____

Prefered Phone Number: _____

Secondary Phone Number: _____

Can we leave information on voicemail? ☐ Y or ☐ N … If so,

Information that can be left on the voicemail:

- ☐ Appointment dates and times from any health care provider
- ☐ Test Results,
- ☐ Follow Up health instructions
- ☐ Other: _____
- ☐ Exclusions:_____

Section B. Authorized Contacts

If the office is unable to reach me, I give them permission to contact the following indivudals:

Contact #1 -

Name:_____ Phone #: _____

Information that can be shared:

- ☐ Appointment dates and times from any health care provider
- ☐ Test Results
- ☐ Follow Up health instructions
- ☐ Other: _____
- ☐ Exclusions:_____

Contact #2 -

Name:_____ Phone #: _____

Information that can be shared:

- ☐ Appointment dates and times from any health care provider
- ☐ Test Results
- ☐ Follow Up health instructions
- ☐ Other: _____
- ☐ Exclusions:_____

Section C. Order of Contact (please number 1,2 or 3)

Myself: ___ Contact #1: ___ Contact #2: ___

The Following people are allowed to book appointments on my behalf:

_____

The Following people are allowed discussions in office on my behalf:

_____

Signed _____ **Date:** _____

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CENTRAL LAMBTON FAMILY HEALTH TEAM

Dr. J. Butler
Dr. S. Cooper
Dr. E. Daniel
Dr. S. Farhangi
Dr. A. Hijazi
Dr. Y. Honjol
Dr. A. Leonard
Dr. J. Mall
Dr. P. Moon / Dr. T. Koreman
Dr. N. Taylor

4130 Glenview Road., Unit 3
Petrolia, Ontario N0N 1R0. 519-882-2500

Welcome to the Central Lambton Family Health Team.
In order to serve you better, we ask that you complete the following:

NAME: _____

Complete Mailing address: Please include 911 number or P O Box

_____

_____

_____

Home Phone #: _____ Cell Phone #: _____

E-mail Address: _____

Employer Name: _____ Phone #: _____

EMERGENCY CONTACT:

Name: _____ Phone #: _____

Relationship: _____

ALTERNATE CONTACT:

Name: _____ Phone #: _____

Relationship: _____

PHARMACY USED FOR PRESCRIPTON

Pharmacy Name _____ Location _____

Previous Doctor _____ Location _____

We ask that you inform our office of any changes to the above information.

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CENTRAL LAMBTON FAMILY HEALTH TEAM

Dr. J. Butler	Dr. A. Hijazi	Dr. J. Mall
Dr. S. Cooper	Dr. Y. Honjol	Dr. P. Moon / Dr. T. Koreman
Dr. E. Daniel	Dr. A. Leonard	Dr. N. Taylor
Dr. S. Farhangi		

4130 Glenview Road., Unit 3
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Telephone: 519-882-2500 Fax: 519-882-4321

REQUEST FOR MEDICAL RECORDS

Dear Dr: _____

The following patient has come under the care of Dr. - _____

( ) and would like a copy of their medical records transferred.

( ) does **not** wish to have their medical records transferred, and wishes to notify you of this change ONLY.

PATIENT: _____

DATE OF BIRTH: _____

OHIP NUMBER: _____

CURRENT ADDRESS: _____

-

_____

_____

TELEPHONE: _____

I agree to release my medical records to Dr: - _____.
I understand that there may be a charge for the transfer of records and I am aware that I will be responsible for any fees associated with the transfer.

_____ _____
Patient Signature (Print name beside signature) Witness Signature (Print name beside signature)

_____ _____
Date Date

Ontario Ministry of Health

Patient Enrolment and Consent to Release Personal Health Information

Your family doctor is a member of a primary health care **Patient Enrolment Model (PEM).** Family doctors work in patient enrolment models to give you and your family continued access to quality primary health care services.

Enrolling with a family doctor who is participating in a PEM is your choice. If you choose to enrol, please fill out this form, **using a black or blue ball point pen**, as follows:

- To enrol **yourself** ..... *complete* ***Sections 1 & 3***
- To enrol **yourself** and up to **two** children under 16 years of age and/or dependent adults for whom you are a parent, legal guardian or attorney for personal care ..... *complete* ***Sections 1, 2 & 3***
- To enrol children under 16 years of age and/or dependent adults for whom you are a parent, legal guardian or attorney for personal care but **not** yourself .... *complete* ***Sections 2 & 3***
- To enrol **more than two** children under 16 years of age or dependent adults for whom you are a parent, legal guardian or attorney for personal care ..... *complete* ***Sections 2 & 3*** *on a separate form*

Note: If the mailing address includes a post office box (P.O. Box), rural route (R.R.), or general delivery, you must also complete the residence address.

If your family doctor is not already identified or is incorrectly identified in Section 4, please print his or her name inside the box in Section 4.

Your family doctor will acknowledge your enrolment form in Section 4 and will provide you with a copy for your records.

For questions about enrolment and consent, filling out this form or to receive additional forms, please call INFOline at 1 888 218–9929 (TTY 1 800 387–5559).

Instructions:

1. Remove this instruction page.
2. Complete the form as instructed above.
3. Read the back of the form and Section 3 before signing it.
4. Return all copies of the completed form in the envelope provided.

PG16443

(Cette formule est aussi disponible en format bilingue. Pour recevoir une copie, composez : 1 888 218–9929)

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Ontario Ministry of Health

Microfilm use only

Patient Enrolment and Consent to Release Personal Health Information

Please PRINT using black or blue ballpoint pen.

Collection of the information on this form is under the authority of the *Ministry of Health Act*, subsection 6(1) and (2) and the *Health Insurance Act*, R.S.O. 1990, c. H.6, s.4(2)(b) and (f), 4.1(1) and (2), 10 and 11(1). For information about collection practices, contact the Director, Registration and Claims Branch, Box 48, 49 Place d'Armes, Kingston ON K7L 5J3, INFOline tel. 1 888 218-9929 or by mail through the addresses listed for local Ministry of Health and Long-Term Care offices.

Section 1 – I want to enrol myself with the family doctor identified in Section 4

Last Name | First Name | Second Name

Health Number | Version Code

Date of Birth *(yyyy/mm/dd)* | Sex ☐ M ☐ F

Send notices from my family doctor's office to me by:
☐ regular mail ☐ email *(if possible)*

Email Address:

Mailing Address ▶ Apartment # | Street No. and Name or P.O. Box, Rural Route, General Delivery

City/Town | Postal Code

Residence Address ▶ Apartment # | Street No. and Name or Lot, Concession and Township

City/Town | Postal Code

or ☐ same as mailing address

Section 2 – I want to enrol my child(ren) under 16 and/or dependent adult(s) with the family doctor identified in Section 4

A

Last Name | First Name | Second Name

Health Number | Version Code

Date of Birth *(yyyy/mm/dd)* | Sex ☐ M ☐ F

I am this person's
◯ parent
◯ legal guardian
◯ attorney for personal care

Mailing Address ▶ Apartment # | Street No. and Name or P.O. Box, Rural Route, General Delivery

City/Town | Postal Code

or ☐ same as Section 1

Residence Address ▶ Apartment # | Street No. and Name or Lot, Concession and Township

City/Town | Postal Code

or ☐ same as Section 1

B

Last Name | First Name | Second Name

Health Number | Version Code

Date of Birth *(yyyy/mm/dd)* | Sex ☐ M ☐ F

I am this person's
◯ parent
◯ legal guardian
◯ attorney for personal care

Mailing Address ▶ Apartment # | Street No. and Name or P.O. Box, Rural Route, General Delivery

City/Town | Postal Code

or ☐ same as Section 1

Residence Address ▶ Apartment # | Street No. and Name or Lot, Concession and Township

City/Town | Postal Code

or ☐ same as Section 1

Section 3 – Signature

I have read and agree to the Patient Commitment, the Consent to Release Personal Health Information and the Cancellation Conditions on the back of this form. I acknowledge that this Enrolment is not intended to be a legally binding contract and is not intended to give rise to any new legal obligations between my family doctor and me.

I am signing on behalf of *(check all that apply)*
◯ myself ◯ child(ren) ◯ dependent adult(s)

My Name
last name | first name

Signature
X

Date *(yyyy/mm/dd)*

Home Telephone No.
( )

Work Telephone No.
( )

Section 4 – Family doctor information

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(Include Billing no. and Group no.)

Family Doctor's Signature
X

Date *(yyyy/mm/dd)*

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