Centre de santé et de services sociaux de Papineau

REGISTRATION FOR A FAMILY DOCTOR

Your name:	First name:
Date of birth:	Health Insurance N°:
Telephone (home):	Other telephone N°:
Address:	Date of application:

Who was your last family doctor?_____

Who prescribes your medications?_____

When do your prescriptions expire?_____

Are you being treated by a specialist?_____

I agree to have a summary of my record transferred to the physician who will take me in charge: Yes ❒ No ❒

Health issues: (diabetes, surgery, etc.)

List of your medications:

⇨**As we cannot guarantee that you will be taken in charge rapidly, we suggest that you go to a walk-in clinic, or to the emergency if necessary.**

Assessment of the application: P Reserved space	Patient informed that he was taken in charge by: Telephone ❒ Letter ❒ Information sent by:
Name of physician to whom the patient was transferred:	Date of transfer:
Signature of person who analyzed the application:	Date:

🖷 *If sent by fax: Department of Professional and Hospital Services at 819 961-8018*

or send by mail to the following address:

Centre de santé et des services sociaux de Papineau
Hôpital de Papineau
Department of Professional and Hospital Services
155, rue Maclaren Est,
Gatineau (Québec), J8L 0C2

(Disponible aussi en français)