Comox Valley
Division of Family Practice
A GPSC initiative

PRIMARY CARE WAITLIST - PRIORITY ACCESS REFERRAL

PATIENT INFORMATION *(Patient label can be attached)*

Full Name *(required)*:	Date of Birth *(required)*:
Address *(required)*:	Email:
Cell/Home Phone *(required)*:	*PHN Number (or equivalent)(required)*

INDICATE ALL THAT APPLY

- ☐ 70+ years old
- ☐ Severe Disability
- ☐ Complex Chronic Conditions
- ☐ New mother & infants (*from pregnancy to 18 months*)
- ☐ Additional referral details:
- ☐ Significant Cancer
- ☐ Mental Health
- ☐ Substance Use

____

____

____

REASON FOR REFERRAL:

- ☐ New to community
- ☐ Unable to find a doctor
- ☐ Physician retired/moved
- ☐ Other ______________________________

OK TO LEAVE A MESSAGE? ☐ YES ☐ NO

REFERRAL DATE/SOURCE Date: ____________________

- ☐ Self-referring
- ☐ Agency, hospital, or clinic referring

Referrer's name: ____

Agency name: ____

Phone number: ____

Do you want to be contacted regarding the outcome of the referral ☐ YES ☐ NO

CONSENT:

I, ____________________________________, consent to my information being shared with (a) the Comox Valley Division of Family Practice for the purpose of registering my need for a primary care provider with HealthLinkBC (Health Connect Registry waitlist) and (b) with a primary care provider for the purpose of attaching to a family practice. The referral source may sign that they have received verbal consent from the patient to make this referral.

Patient, guardian or Power of Attorney Signature: ____

Date: ____

Witness Signature: ____

Date: ____

Fax this completed form to: 1 866 386 2224

Completion of this form does not guarantee availability of a physician.
Contact the Attachment Administrator at:
236-793-4647 | hcr.comoxvalleyadmin@comoxvalleydivision.ca

British Columbia | HealthLinkBC

Primary Care Network Comox Valley