Centre intégré
de santé
et de services sociaux
des Îles

Québec

REGISTRATION FORM
FOR PEOPLE WITHOUT A FAMILY DOCTOR

USER IDENTIFICATION

Qc Health card number: __ __ __ __ __ __ __ __ __ __ __ __ ☐ Male ☐ Female

Birth date:_ _ _ _ / _ _ / _ _ Language : □ French □ English □ Other

Family name : _____ First name :_____

Adress : _____

City : _____ Postal code : _____

Phone number at home : _____ Work: _____ Cellular : _____

PROCESS

- To register, you must complete the form in full and attach a list of your medications.
- If your health condition changes, it is your responsibility to complete a new form. We can then make changes to your form.

TO NOTE

- Please note that completing this form does not guarantee immediate access to a family doctor. Once we receive your form, you will be registered on a list of users on hold. Each request is subject to evaluation to determine priority, and so allows us to assign you a doctor as soon as possible, while considering important health issues.

PLEASE SEND YOUR REQUEST TO ONE OF THE FOLLOWING LOCATIONS

- Reception of CISSS des Îles
- The receptionist of your medical clinic (family doctor)
- CLSC Points of service (Grindstone, Bassin, Old Harry, Entry Island)

Presently, do you receive services from the CSSS des Îles? □ YES □ NO
If so, which ones? _____

Did you use the emergency department services in the last year? □ YES □ NO
How many times ? □ 1-3 times □ 4-7 times □ 8 times and more

Were you hospitalised in the last year? □ YES □ NO
If so, why? _____

Did you have a surgery in the last 2 years? □ YES □ NO
If so, which? _____

Do you wish to have a different family doctor from the one you have now ? □ YES □ NO
If so, who is your current doctor? _____
Reason for the request to change : _____

CONSENT

I authorize medicals professionals to store my medical information in a secure central bank, all in strict compliance with confidentiality rules. I also authorize medicals professionals to consult my file as needed in relation to this request.

Signature : _____ **Date :** _____

MEDICALS INFORMATIONS (Check all options that apply to your health)

❑ No known disease OR

Heart diseases :
- ☐ High blood pressure
- ☐ Angina / previous heart attack
- ☐ Heart failure
- ☐ Atherosclerosis / dyslipidemia (cholesterol)
- ☐ Atrial fibrillation
- ☐ Cerebral vascular accident (stroke)
- ☐ Thrombophlebitis
- ☐ Other : _____

Pulmonary diseases :
- ☐ Chronic obstructive pulmonary disease (COPD)
- ☐ Asthma
- ☐ Pulmonary embolism
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Other : _____

Endocrine diseases :
- ☐ Type 1 diabetes
- ☐ Type 2 diabetes
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Other :_____

Digestive diseases :
- ☐ Crohn's disease
- ☐ Irritable bowel syndrome
- ☐ Ulcerative colitis
- ☐ Cirrhosis
- ☐ Other : _____

Joint diseases :
- ☐ Arthritis / osteoarthritis
- ☐ Osteoporosis
- ☐ Chronic pain : specify:
- ☐ Other : _____

Neurological disorders :
- ☐ Attention deficit disorder
- ☐ Multiple scleroris
- ☐ Parkinson's disease
- ☐ Alzheimer's disease
- ☐ Other : _____

Mental health problems :
- ☐ Depression
- ☐ Anxiety
- ☐ Panic disorder
- ☐ Schizophrenia
- ☐ Borderline personality disorder
- ☐ Bipolar disorder (manic depressive)
- ☐ Eating disorders
- ☐ Other : _____

Urologic diseases :
- ☐ Prostate disease
- ☐ Urinary incontinence
- ☐ Other : _____

Kidney diseases :
- ☐ Kidney failure
- ☐ Kidney infection
- ☐ Other : _____

Skin disorders :
- ☐ Psoriasis
- ☐ Eczema
- ☐ Other : _____

Drugs and alcohol:
- ☐ Drugs
- ☐ Alcohol

HIV/AIDS
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Other : _____

Other :
- ☐ Visual disabilities
- ☐ Hearing loss
- ☐ Intellectual disability
- ☐ _____

Cancer :
- ☐ Type :
- ☐ Date of diagnosis :
- ☐ Cancer treatment
  - ☐ Chemotherapy
  - ☐ Radiotherapy
- ☐ Date of cancer remission :
- ☐ Palliative care