



REACH

Community Health Centre

Celebrating nearly 50 years of community health in community hands.

Medical Patient Application Form

Please complete this application in full and email to mreception@reachcentre.bc.ca. Please note that forms will not be completed for at least 1 month and narcotics or controlled drugs will not be prescribed on the first visit.

Last Name: _____ First Name: _____ DOB: _____

Preferred Name: _____ Phone: (____) _____ Gender: M F Other

Email: _____ PHN: _____

Address (apt, address, city, postal): _____

1

Do you have a family doctor Y N If yes... Name: _____
or attend a walk-in clinic? Clinic Name or Address: _____

2

Referral: Self Agency Name: _____
 Agency Agency Contact Person: _____
Agency Email/Phone: _____

3

Medical Information:

- Active Drug or Alcohol Problems
- Opioid Replacement Therapy
- COPD/Emphysema
- Active Mental Health Problems
- High Blood Pressure
- Other: _____
- Diabetes
- Heart Failure
- Hepatitis/HIV

- Housebound requiring a home visit
- MSP subsidized by government
- Struggles to make ends meet
- Need support with social assistance
- English **not** primary language

Primary Language: _____

4

Do you self-identify as:

- LGBTQ2+
- New Immigrant
- First Nations/Aboriginal
- Refugee
- Person with Disability

5

How many times have you been hospitalized in the past 12 months? _____

What hospital? _____

Are you a dependent of or responsible for the care of a patient at REACH? Y N

Family Members Names: 1. _____ 2. _____

3. _____ 4. _____

Each family member (excluding children) requires their own application form.

Interested in dental services as well? Ask us how!