Cascade Medical Centre
BOX 610 PRINCETON, BC V0X 1W0
OFFICE: (250) 295-4482 FAX: (250) 295-4484

Patient Request for Attachment

Date: _____

Patient information:

Name: _____ Gender: _____ Age: _____ Date of Birth: _____
(day / month/ year)

Mailing Address: _____ Care Card Number: _____

City: _____ Phone #: _____ Cell/Alt Number: _____

Email: _____ **Current Family Doctor:** _____

Other Health Care Providers: _____

Medical Information

Allergies: _____

Current Medical Problems: (ie diabetes, high blood pressure, mental health): _____

_____

Current Medications & Dosages (Prescription, over the counter, vitamins): _____

_____

Past Surgeries: _____

Past Serious conditions, illnesses, injuries and or hospitalizations (& dates): _____

_____

Please list your health concerns, in order or importance to you:

1. _____ 3. _____
2.
3. _____ 4. _____

If known – date of last pap, mammogram, colonoscopy or prostate check: _____

Anything else you think is important for us to know: _____

_____

By filling out and signing this form, you are agreeing that your former practitioner will no longer be seeing you as a patient once your chart is transferred to Cascade Medical Centre. Please discuss this with your former practitioner if you have concerns. A release of records form will be signed at your first appointment. ***IF THIS FORM IS NOT COMPLETE IT WILL NOT BE PROCESSED***

Signature: _____