



# REQUEST FOR SERVICES

**Surname, Name:** \_\_\_\_\_  
 (at birth)  
**Sex :** M  F   
**Medicare number :** \_\_\_\_\_  
**Expiry date (yy/mm) :** \_\_\_\_\_  
**D.O.B. (yy/mm/dd):** \_\_\_\_\_  
**File number:** \_\_\_\_\_

## 1. GENERAL INFORMATION

**PERMANENT ADDRESS :** \_\_\_\_\_  
CIVIC NUMBER                      STREET                      APP.                      CITY                      PROVINCE                      POSTAL CODE

**TELEPHONE:** HOME : ( ) \_\_\_\_\_ TTY:  VCO :   
 WORK : ( ) \_\_\_\_\_ (MOTHER) TTY:  VCO :   
 ( ) \_\_\_\_\_ (FATHER) TTY:  VCO :   
 OTHER: \_\_\_\_\_  
 EMAIL: \_\_\_\_\_

**CONTACT PERSON :** \_\_\_\_\_ **RELATION :** \_\_\_\_\_  
 HOME : ( ) \_\_\_\_\_ TTY:  VCO :  WORK : ( ) \_\_\_\_\_ TTY:  VCO :

**FATHER'S NAME :** \_\_\_\_\_ **MOTHER'S NAME (AT BIRTH) :** \_\_\_\_\_

**LANGUAGES SPOKEN :**  FRENCH       ENGLISH       ASL       OTHER, SPECIFY : \_\_\_\_\_

**HOME ENVIRONMENT :**  BIRTH FAMILY       OTHER, SPECIFY : \_\_\_\_\_

**LEGAL GUARDIAN:** \_\_\_\_\_

**CURATORSHIP :**  NO     YES     PUBLIC     PRIVATE    **AUTHORIZED REPRESENTATIVE :** \_\_\_\_\_

## 2. MEDICAL INFORMATION

**DIAGNOSIS OR DIAGNOSTIC IMPRESSION :** \_\_\_\_\_  
**REASON FOR REFERRAL :** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PAST AND PRESENT FOLLOW-UP, REFERRAL TO OTHER ORGANISATIONS (IF APPLICABLE) :** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**FAMILY DOCTOR :** \_\_\_\_\_ **TEL. : ( )** \_\_\_\_\_

**ADDRESS :** \_\_\_\_\_

**SERVICES RECEIVED IN THE COMMUNITY (EX. : CLSC, DAYCARE, REHABILITATION CENTER, CSSS, ETC.)**  
 1. \_\_\_\_\_  
 2. \_\_\_\_\_  
 3. \_\_\_\_\_

**ALLERGIES**  
 NONE  
 FOOD (SPECIFY) \_\_\_\_\_  
 ENVIRONMENTAL (SPECIFY) \_\_\_\_\_  
 MEDICATION(SPECIFY) \_\_\_\_\_

## 3. RÉFERRAL SOURCE

**REFERRED BY :** \_\_\_\_\_  
**TELEPHONE :** ( ) \_\_\_\_\_ **FAX :** ( ) \_\_\_\_\_ **DATE :** \_\_\_\_\_