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Introduction

As a physician in a Primary Care group you play an integral role in enrolling patients and maintaining your patient roster. The instructions provided in this manual will outline the role that you and your staff have in the process of patient enrolment and the removal of patients from the roster.

This reference manual will assist you with:

- Completing the Patient Enrolment and Consent to Release Personal Health Information forms:
  - #4408-80 See sample Appendix A (Individual Enrolment)
  - #4453-80 See sample Appendix B (Group Enrolment)

- Completing the Request to Change Designated Physician form # 4573-84. See sample Appendix C

- Batching the completed Patient Enrolment and Consent to Release Personal Health Information forms (see Appendix A) for submission to the ministry. This will be referred to as the Enrolment/Consent form(s) in this document

- Following up on rejected Patient Enrolment and Consent to Release Personal Health Information and Primary Care Request to Change Designated Physician forms. See samples Appendices A - C

- Completing Request to Remove Patient form # 3624-84. See sample Appendix E

- Updating your enrolled patients’ addresses (see sample Appendix I) listed as What’s Your Address (Change of Address) form # 1057-82

Contacts

If you have any questions about the reference manual please contact your ministry representative at 1 866 766-0266, or the Ministry of Health and Long-Term Care (MOHLTC) Service Support Contact Centre at 1 800 262-6524, or 613 548-7981 from within the Kingston area.

Aussi disponible en français. Pour recevoir une copie, composez le 1 800 262-6524

Ordering Forms

The forms listed below are available for downloading through the Ministry of Health and Long-Term Care, Forms Online Catalogue website under the Primary Health Care listing at: http://www.health.gov.on.ca/english/public/forms/form_menus/primary_fm.html

OR

Contact the Ministry of Health and Long-Term Care Help Desk:
1 800 262-6524 or 613 548-7981 from within the Kingston area. They will fax a copy of the form for your use.

Ministry of Health and Long-Term Care (MOHLTC)
Service Support Contact Centre
1055 Princess Street, Suite 302
Kingston, ON K7L 5A9
Ordering Forms - continued

E-mail: SSContactCentre.MOH@ontario.ca or call at 1 800 262-6524, or 613 548-7981 from within the Kingston area.

Request to Change Designated Physician form # 4573-84 (see sample Appendix C).
Primary Care Patient Enrolment Batch Header form # 4316-84 (see sample Appendix D).
Primary Care Request to Remove a Patient form # 3624-84 (see sample Appendix E).
Request for Primary Health Care Enrolment Material form # 4832-84 (see sample Appendix J).
Request for Primary Health Care Enrolment Material for Comprehensive Care Model (CCM) Physicians Only form # 4833-84 (see sample Appendix K).

Enrolment Supplies

Patient Enrolment and Consent to Release Personal Information forms (Enrolment/Consent Forms) as well as other enrolment materials can be ordered by completing the Request for Primary Health Care Enrolment Material form available on our public website and submitting it as per the instructions on the form.
1.0 Types of Enrolment Transactions

There are three types of transactions described in this manual:

1. Enrolling a patient to a physician’s roster.
2. Removing a patient from a physician’s roster.

Note: Throughout this document:

- The term “group” refers to all Patient Enrolment Models (PEMs); only these models enroll patients.
- The group number refers to your group registration number. This is the four letter alpha/numeric combination (e.g., BXXX, FXXX, or M000) that is assigned once a Primary Care group is registered with the ministry.
- The term ‘enrol’ and its derivatives are used to reference all patient enrolment activity.
- The Patient Enrolment and Consent to Release Personal Health Information form #4408-80 (see Appendix A) will be referred to as the Enrolment/Consent form.

1.1 Enrolling a Patient to a Physician’s Roster

To enrol, a patient must complete and sign the Patient Enrolment and Consent to Release Personal Health Information form. All incomplete forms received from physicians/groups for processing by the ministry will be returned to the physician for follow-up, correction and re-submission.

1.2 Enrolling a Patient to a Group

Physicians and groups (except Comprehensive Care Model) have the option of selecting Group Enrolment and Consent, to allow a patient to enroll to the entire group rather than one individual physician.

Under group enrolment and consent, a patient enrolls with an individual designated physician within a PEM group, however the patient provides consent to disclose personal health information to all the other physicians within that PEM group. As consent is given to the entire group, this ensures that if the designated physician changes their membership within the group, the patient will not have to re-enroll if they choose to stay with the same PEM group.
If your group is interested in changing from individual to group enrolment, please contact the ministry at 1-866-7660266. To enroll in a group, once the group has registered with group enrolment, the patient must complete and sign the Patient Enrolment and Consent to Release Personal Health Information form #4453-80 (Group Enrolment). Refer to sample Appendix B in this manual. The patient completes and signs this form in the same manner as the individual form. The designated physician also needs to sign or stamp the form in acknowledgement. All Enrolment/Consent form(s) must include the physician, the group number and physician’s billing number. The enrolment portion of the group form is the same as the standard Patient Enrolment and Consent to Release Personal Health Information form # 4408-80 (Individual Enrolment); however, the cover page and back of the group form is different.

To change the designated physician for an individual patient, either the patient may fill out a new Enrolment/Consent group form, or the physician can submit a Request to Change Designated Physician form #4573-84. Refer to Appendix C. This form must have the signature or acknowledgement stamp of both the current and the new designated physician to be valid. If the change is initiated by a physician, the patient must be notified of the change in designated physician.

The completed form should be submitted with the next batch of Enrolment/Consent forms. There should always be a batch header form when submitting a Request to Change Designated Physician form # 4573-84 whether with other forms, or individually.

1.3 Removing a Patient from a Physician’s Roster

On occasion, a patient may need to be removed from your roster. This transaction may be initiated by the PEM physician, the patient or the ministry depending on the reason for removal. To enable the physician to remove a patient from the roster, the physician must complete a Primary Care Request to Remove A Patient form # 3624-84 (refer to Appendix E).
2.0 Enrolment Process

This section provides a summary of the steps involved to enrol a patient with a PEM physician/group.

2.1 Patient Receives Enrolment/Consent Form

Patients may receive an Enrolment/Consent form when they visit their PEM physician, or through a mailing. Refer to Appendix A for a sample of the Patient Enrolment and Consent to Release Personal Health Information form #4408-80.

2.2 Patient Completes and Signs Enrolment/Consent Form

Patients wishing to enrol themselves, children under the age of 16 years, or dependent adults\(^1\) must complete and sign an Enrolment/Consent form. A patient and up to two children may be enrolled on one form. This form cannot be photocopied. The original triplicate Enrolment/Consent form must be completed in full.

2.3 Patient Submits Enrolment/Consent Form

Patients may drop off their completed/signed form at their PEM physician’s office or mail the form to their physician.

2.4 Physician Reviews Enrolment/Consent Form

The ministry recommends that before acknowledging the Enrolment/Consent form, that it is reviewed for completeness. The most common reasons why the ministry rejects forms are:

- incomplete or incorrect health number
- missing (patient or physician) signature
- missing enrolment effective date
- more than one physician’s name indicated on the form

All incomplete forms received by the ministry will be returned to the physician for follow-up, correction and re-submission.

To minimize the number of Enrolment/Consent forms returned, and to avoid delays, the ministry recommends using a checklist when reviewing information contained on the form – Refer to Appendix F for “Checklist for a Completed Enrolment/Consent Form”.

\(^1\) A guardian or person with power of attorney for personal care can enrol an individual in their care and sign the enrolment/consent form on their behalf.
2.5 Physician Acknowledges Enrolment/Consent Form

The PEM physician must acknowledge the form by:

- signing the form (the physician’s group number and billing number are also required),

or

- stamping all copies of the form using the acknowledgement stamp provided by the Ministry of Health and Long-Term Care

2.6 Distribution of Enrolment/Consent Form

The Enrolment/Consent form is in triplicate and distributed by the PEM physician as follows:

- white (ministry) copy is batched and sent to the ministry – (Refer to section 3.0 Batching and Submitting Completed Enrolment/Consent Forms

- yellow (patient) copy is returned to the patient

- pink (physician) copy is retained by the physician
3.0 Batching and Submitting Completed Enrolment/Consent Forms

Once the completed Enrolment/Consent forms have been reviewed and acknowledged, they must be batched and mailed to the ministry. This section outlines the procedures for sending completed forms to the ministry.

While it is not necessary to maintain a strict schedule for batching and sending forms to the ministry, you may choose to batch forms according to a schedule (e.g., weekly/biweekly) that is convenient for your office.

3.1 Batching Forms

The Batch Header is the cover page that accompanies each batch of Enrolment/Consent forms submitted to the ministry. A sample of the Primary Care Patient Enrolment Batch Header form is included as Appendix D.

For convenience, address labels may be applied in section 3 “Physician Information” of the Primary Care Patient Enrolment Batch Header form. Batches from more than one physician can be included in an envelope. However, only Enrolment/Consent forms from a single physician can be included in each batch.

The ministry no longer provides pre-addressed, postage-paid envelopes (or envelopes with mailing labels) in which to submit batches of the Enrolment/Consent forms. Physicians may send batched forms by the delivery method of their choice, e.g. regular mail or registered mail, to the following address:

Ministry of Health and Long-Term Care
Enrolment Processing Unit
49 Place d’Armes
PO Box 48,
Kingston, ON K7L 5J3

Primary Care Patient Enrolment Batch Header forms # 4316-84 are available for downloading from the Ministry of Health and Long-Term Care Forms Online Catalogue web site under the Primary Health Care listing at:

3.2 Submitting Forms

3.2.1 A batch may contain up to a maximum of 100 white copies of the Enrolment/Consent Forms. The ministry must receive the white copy with the patient’s original signature and date for enrolment and consent purposes.

3.2.2 Place a completed Batch Header on top of each batch of forms and send to the ministry by the delivery method of your choice, e.g. regular, or registered mail. Include a separate Batch Header for each batch of forms. When completing the Batch Header please be sure to include the following:

- Physician’s name and address printed clearly or affix an address label
- Physician Billing Number
- Group number (e.g., BBZZ)
- Group Name
- Mailing Date
- Number of Forms
4.0 Rejected Enrolment/Consent Forms

*Patient Enrolment and Consent to Release Personal Health Information* forms that the ministry is unable to process are returned to the PEM physician’s office. There could be a variety of reasons for returning these forms including:

- missing information
- ineligibility for health coverage
- incorrect/invalid health number

An Enrolment/Consent form that is returned for follow-up, correction and re-submission will have a return notification attached indicating the reason it was rejected. Refer to Appendix G for the MOHLTC covering letter *Primary Care - Request for Information to Process Enrolment/Consent Forms* # 4314-84.

A form may include up to three patients and three health numbers. Therefore, the form could be rejected in whole or in part.

a. If the whole form is rejected, the original will be returned for follow-up. Where possible, complete/correct the form.

b. If only part of the form is rejected, the original form will be returned for follow-up. The successfully processed enrolment(s) will be stamped “Enrolled”, which will allow you to identify the portion that requires completion/correction.

All corrected forms should be batched using normal procedures and returned to the ministry. Refer to section 3: “*Batching and Submitting Completed Enrolment/Consent Forms*”. 
5.0 Removing a Patient From Your Roster

The PEM physician, a patient or the ministry may end enrolment subject to the restrictions set out on the back of the Enrolment/Consent form (refer to Appendix A). In cases where the physician ends a patient’s enrolment, a Primary Care Request to Remove a Patient form # 3624-84 is completed by the physician and mailed to the ministry. Refer to Appendix E for a sample of the Primary Care Request to Remove a Patient form.

This form provides the reason codes for removing a patient from the roster.

*Note: If the physician has terminated the enrolment, please ensure the patient is notified that enrolment has ended.*

- A separate form must be submitted for each patient removed from your roster
- Send the original form to the ministry for processing. The form may be included with your batched enrolment forms
- A photocopy of the form should be retained by the physician

The Primary Care Request to Remove a Patient form # 3624-84 is available for downloading from the Ministry of Health and Long-Term Care Forms Online Catalogue website under the Primary Health Care listing at:


OR

Contact the Ministry of Health and Long-Term Care (MOHLTC)
Service Support Contact Centre
1055 Princess Street, Suite 302
Kingston, ON K7L 5A9

E-mail: SSContactCentre.MOH@ontario.ca or call at 1 800 262-6524, or 613 548-7981 from within the Kingston area. They will fax you a copy of the form.

5.1 Patient Initiated Request

Enrolment is voluntary, if a patient wishes at any time to be removed from your roster they may contact the Service Ontario INFOline at 1-888-218-9929; they will be required to provide their rostered physicians name and their health card number to the agent in order to complete this process over the telephone.
6.0 Rejected “Request to Remove a Patient” Form

The ministry may be unable to process a Primary Care Request to Remove a Patient form for a variety of reasons including:

- missing information
- the health number is invalid or missing
- the patient is not enrolled with the physician specified (e.g., patient’s enrolment has previously been ended or patient has enrolled with another physician)

All forms that are returned to the PEM physician for follow-up, correction and re-submission will have a return notification attached indicating the reason the form was rejected. Refer to Appendix H for a sample of the MOHLTC covering letter - Primary Care Request for Information to Remove a Patient form # 4315-84.
7.0 Updating a Patient’s Address

*It is important that the ministry has the patient’s current address on file.*

To ensure that the ministry has up-to-date patient mailing and residential addresses, physicians are encouraged to remind their patients to notify the ministry when they move.

If a patient informs you of an address change, the patient must complete and submit the *What’s Your Address (Change of Address)* form #1057-82. Refer to Appendix I to the ministry address indicated on the form.

Patients can obtain *What’s Your Address (Change of Address)* form #1057-82 from a local ServiceOntario office or the form can be downloaded from the Government of Ontario Central Forms Site at:


Enter 1057-82 in the Quick Search window and click on GO!
APPENDIX A (Individual Enrolment)

Patient Enrolment and Consent to Release Personal Health Information
Inscription du patient et consentement à la divulgation de renseignements médicaux personnels

Your family doctor is a member of a primary health care Patient Enrolment Model (PEM). Family doctors work in patient enrolment models to give you and your family continued access to quality primary health care services.

Enrolling with a family doctor who is participating in a PEM is your choice. If you choose to enrol, please fill out this form, using a black or blue ball point pen, as follows:

- To enrol yourself ................................................................. complete Sections 1 & 3.
- To enrol yourself and up to two children under 16 years of age and/or dependent adults for whom you are a parent, legal guardian or attorney for personal care ................................................................. complete Sections 1, 2 & 3.
- To enrol children under 16 years of age and/or dependent adults for whom you are a parent, legal guardian or attorney for personal care but not yourself ................................................................. complete Sections 2 & 3.
- To enrol more than two children under 16 years of age and/or dependent adults for whom you are a parent, legal guardian or attorney for personal care ................................................................. complete Sections 2 & 3 or a separate form.

Note: If the mailing address includes a post office box (R.O. Box), rural route (R.R.), or general delivery, you must also complete the residence address.

If your family doctor is not already identified or is incorrectly identified in Section 4, please print his or her name inside the box in Section 4.

Your family doctor will acknowledge your enrolment form in Section 4 and will provide you with a copy for your records.

For questions about enrolment and consent, filling out this form or to receive additional forms, please call INFOline at 1 888 216-0929 (TTY 1 800 387-5559).

Votre médecin de famille fait maintenant partie d'un modèle d'inscription de patients (le « modèle ») pour les soins de santé primaires. Les médecins de famille travaillent au sein de tels modèles pour vous assurer, à vous et à vos enfants, un accès continu à des services de soins de santé primaires de qualité.

L’inscription auprès d’un médecin de famille participant à un tel modèle est facultative. Si vous décidez de vous inscrire, veuillez remplir le présent formulaire (servez-vous d’un stylo à bille à encre bleue ou noire) comme suit:

- Pour vous inscrire ................................................................. remplissez les Parties 1 & 3.
- Pour vous inscrire et inscrire un ou deux enfants de moins de 16 ans et/ou des adultes à charge dont vous êtes parent, tuteur légal ou procureur aux soins de la personne ................................................................. remplissez les Parties 1, 2 & 3.
- Pour inscrire des enfants de moins de 16 ans et/ou des adultes à charge dont vous êtes parent, tuteur légal ou procureur aux soins de la personne, mais sans vous inscrire vous-même ................................................................. remplissez les Parties 2 et 3.
- Pour inscrire plus de deux enfants de moins de 16 ans ou des adultes à charge dont vous êtes parent, tuteur légal ou procureur aux soins de la personne ................................................................. remplissez les Parties 2 et 3 sur un formulaire distinct.

Remarque : Si votre adresse postale est une case postale (CP), une route rurale (RR) ou la poste restante (PR), vous devez également remplir la section de l’adresse du domicile.

Si votre médecin de famille n’est pas déjà identifié ou n’est incorrectement à la Partie 4, veuillez écrire son nom en caractères d’imprimerie dans la case prévue à cette fin à la même Partie.

Votre médecin de famille accusera réception de votre formulaire d’inscription en remplissant la Partie 4 et il vous en remettra une copie pour vos dossiers.

Si vous avez des questions au sujet de l’inscription et du consentement, ou si vous rendez savoir comment remplir le formulaire ou en obtenir des exemplaires supplémentaires, veuillez appeler le Ligne INFO au 1 888 216-0929 (ATS : 1 800 387-5559).

Please see reverse for more Instructions. Veuillez consulter l’endos pour de plus amples directives.
Patient Enrolment and Consent to Release Personal Health Information
Inscription du patient et consentement à la divulgation de renseignements médicaux personnels

Instructions:
1. Remove this instruction page.
2. Separate the English and French form at the separating tissue.
3. Complete either the English or French form.
4. Read the back of the form and Section 3 before signing it.
5. Discard the separating tissue and the unused form.
6. Return all copies of the completed form in the envelope provided.

Directives:
1. Retirer cette feuille de directives.
2. Séparer le formulaire français du formulaire anglais à la feuille intercalaire.
3. Remplir le formulaire français ou le formulaire anglais.
4. Lire le verso du formulaire ainsi que la Partie 3 avant de signer.
5. Jeter la feuille intercalaire et le formulaire non utilisé.
6. Renvoyer toutes les copies du formulaire rempli dans l’enveloppe fournie à cet effet.
Patient Enrolment and Consent to Release Personal Health Information

Patient Commitment
I agree to contact my family doctor, (or if applicable the group to which my family doctor belongs or the designated Telephone Health Advisory Service if available to me), when I, or my enrolled child(ren) or dependent adult(s), need primary care medical advice or treatment. I promise to do this unless there is an emergency or I am travelling away from home.

I agree that if I or the person(s) I have signed for move, I will contact my family doctor’s office or the Ministry (see box below) with a new address and telephone number.

I understand that I can end my enrolment with this family doctor and enrol with another family doctor after six weeks have passed from the date that I complete and sign this form (immediately if I have moved). However, I agree not to change the doctor with whom I am enrolled more than twice a year.

I understand that by enrolling a child under 16 or a dependent adult, my signature on the front of this form means that I agree to these terms and conditions on behalf of that person. When an enrolled child reaches 16 years of age, the ministry will contact him or her to confirm enrolment/consent with the family doctor.

Consent to Release Personal Health Information
I understand that my family doctor will be able to offer better medical care if I permit my family doctor and the ministry to share appropriate and relevant information relating to my health.

I agree to allow my family doctor, other family doctors in the Patient Enrolment Module (if applicable), and the ministry to exchange the information in this form related to my enrolment.

I agree that my family doctor and the ministry can exchange information about my name, address and telephone number.

I agree to allow the ministry to release the following specific information to my family doctor:
- dates of immunizations (flu shots, etc.)
- dates of preventive care screening services (pap tests, mammograms, etc.)
- dates of service, fees paid and fee codes of primary health care services provided to me by a family doctor outside my family doctor’s Patient Enrolment Module (if applicable).

If the Telephone Health Advisory Service is available to me, I agree to allow my family doctor and the ministry to exchange only the following information with the designated Telephone Health Advisory Service: my name, health number and version code, address, date of birth, gender.

I understand that this consent to release personal health information ends when:
- My enrolment with my family doctor ends.
- I cancel my consent by writing or telephoning the Ministry of Health and Long-Term Care (see box below).

The ministry will inform my family doctor when the consent is no longer valid. However, I understand that the information already released to my family doctor will remain in my medical file.

Cancellation Conditions
Enrolment with my family doctor and my consent to release personal health information will end when:

a) I cancel my enrolment by writing my family doctor or by writing or telephoning the ministry (see box below);
b) I no longer qualify for health care services under the Health Insurance Act (Ontario);
c) the Patient Enrolment Module to which my doctor belongs no longer exists;
d) my family doctor chooses to discontinue acting as my family doctor in accordance with the College of Physicians and Surgeons of Ontario guidelines;
e) I enrol with another family doctor;
f) the ministry grants me an extended absence.

My enrolment with my family doctor and my consent to release personal health information may end when:

a) I consistently fail to meet the obligations to which I agreed in the Patient Commitment (above);
b) my family doctor leaves this Patient Enrolment Module;
c) I become a resident of a long-term care facility;
d) I am imprisoned in a provincial or federal correctional institution; or
e) I move outside the geographic area where the Patient Enrolment Module to which my family doctor belongs regularly provides services.

Contact Information:
Ministry of Health and Long-Term Care
P.O. Box 48, Station Main
Kingston ON K7L 9Z9
Call: INFline 1 888 218-9929
TTY 1 800 332-5529
Ontario
Ministère de la Santé
des Soins de longue durée

Inscription du patient et consentement à la divulgation de renseignements médicaux personnels

Veuillez acter en CARACTÈRES D'IMPRIMERIE au style noir ou bleu.

L'information contenue dans ce formulaire est protégée par les paragraphes 8 (1) et 20 (2) de la Loi sur la protection de la vie privée ainsi que les paragraphes 4 (1) et (2), l'article 11 de la loi sur l'assurance-sante (L.R.O. 1995, c. H.14). Pour en tenir compte, nous vous félicitons d'avoir lu attentivement le décret de l'hydrostacte et des demandes de règlement qui passe p. 8, 40, 45. Place d'Armes, Kingston DI, K7K 5G2. Copie de l'adresse de l'hydrostacte du ministère de la Santé et des Services de santé.

Partie 1 – Je veux m'inscrire auprès du médecin de famille indiqué à la Partie 4

<table>
<thead>
<tr>
<th>Nom de famille</th>
<th>Prénom</th>
<th>Deuxième prénom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numéro de carte Santé</td>
<td>Version</td>
<td>Adresse postale</td>
</tr>
<tr>
<td>Date de naissance (aaaa/mm/jj)</td>
<td>Sexe (M/F)</td>
<td>App. Numéro et nom de la rue ou case postale, route rurale, poste restante</td>
</tr>
<tr>
<td>Emplacement du courrier provenant du bureau de mon médecin de famille par :</td>
<td></td>
<td>Ville/Municipalité</td>
</tr>
<tr>
<td>Poste normale</td>
<td>Courrier électronique (si possible)</td>
<td>Code postal</td>
</tr>
<tr>
<td>Adresse du domicile</td>
<td>App. Numéro et nom de la rue ou emplacement, concession et canton</td>
<td></td>
</tr>
<tr>
<td>ou même adresse que l'adresse postale</td>
<td>Ville/Municipalité</td>
<td>Code postal</td>
</tr>
</tbody>
</table>

Partie 2 – Je veux m'inscrire mon ou mes enfants de moins de 18 ans et/ou un ou des adultes à ma charge auprès du médecin de famille indiqué à la Partie 4

<table>
<thead>
<tr>
<th>Nom de famille</th>
<th>Prénom</th>
<th>Deuxième prénom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numéro de carte Santé</td>
<td>Version</td>
<td>Adresse postale</td>
</tr>
<tr>
<td>Date de naissance (aaaa/mm/jj)</td>
<td>Sexe (M/F)</td>
<td>App. Numéro et nom de la rue ou case postale, route rurale, poste restante</td>
</tr>
<tr>
<td>Je suis :</td>
<td></td>
<td>Ville/Municipalité</td>
</tr>
<tr>
<td>□ parent</td>
<td></td>
<td>Code postal</td>
</tr>
<tr>
<td>□ tuteur légal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ procureur aux soins de la personne</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adresse du domicile</td>
<td>App. Numéro et nom de la rue ou emplacement, concession et canton</td>
<td></td>
</tr>
<tr>
<td>ou même adresse que l'adresse postale</td>
<td>Ville/Municipalité</td>
<td>Code postal</td>
</tr>
</tbody>
</table>

Partie 3 – Signature

J'ai lu et accepte l'engagement du patient, je conserve à la divulgation des renseignements médicaux personnels et j'accepte les conditions d'annulation stipulées à l'adresse de ce formulaire. Je reconnais que cette inscription ne constitue pas un contrat échangeé et n'a pas pour effet de créer d'obligations juridiques entre mon médecin de famille et moi.

Je signe au nom de (cochez toutes les personnes concernées):
□ Mon-mère
□ Enfant(s)
□ Adulte(s) à charge

Nom du requérant

<table>
<thead>
<tr>
<th>Nom</th>
<th>Prénom</th>
</tr>
</thead>
</table>

Signature

Date (aaaa/mm/jj)

Partie 4 – Renseignements sur le médecin de famille

<table>
<thead>
<tr>
<th>Nom du médecin de famille</th>
<th>Signature</th>
</tr>
</thead>
</table>

Indiquer le numéro de facturation et le numéro de groupe

<table>
<thead>
<tr>
<th>Téléphone à la maison</th>
<th>Téléphone au travail</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Signature de l'enfant</th>
<th>Date (aaaa/mm/jj)</th>
</tr>
</thead>
</table>


(Dépot à l'Office du Canada, 2004.)
Patient Enrolment and Consent to Release Personal Health Information
Inscription du patient et consentement à la divulgation de renseignements médicaux personnels

Your family doctor is a member of a primary health care Patient Enrolment Model (PEM). Family doctors work in patient enrolment models to give you and your family continued access to quality primary health care services.

Enrolling with a family doctor who is participating in a PEM is your choice. If you choose to enrol, please fill out this form, using a black or blue ball point pen, as follows:

• To enrol yourself .............................................................. complete Sections 1 & 3
• To enrol yourself and up to two children under 16 years of age and/or dependent adults for whom you are a parent, legal guardian or attorney for personal care ........................................ complete Sections 1, 2 & 3
• To enrol children under 16 years of age and/or dependent adults for whom you are a parent, legal guardian or attorney for personal care but not yourself ........................................ complete Sections 2 & 3
• To enrol more than two children under 16 years of age or dependent adults for whom you are a parent, legal guardian or attorney for personal care ........................................ complete Sections 2 & 3 on a separate form

Note: If the mailing address includes a post office box (P.O. Box), rural route (R.R.), or general delivery, you must also complete the residence address.

If your family doctor is not already identified or is incorrectly identified in Section 4, please print his or her name inside the box in Section 4.

Your family doctor will acknowledge your enrolment form in Section 4 and will provide you with a copy for your records.

For questions about enrolment and consent, filling out this form or to receive additional forms, please call INFOline at 1 888 218-0929 (TTY 1 866 367-5539).

Votre médecin de famille fait maintenant partie d’un modèle d’inscription de patients (le « modèle ») pour les soins de santé primaires. Les médecins de famille travaillent au sein de tels modèles pour vous assurer, à vous et à vos enfants, un accès continu à des services de soins de santé primaires de qualité.

L’inscription auprès d’un médecin de famille participant à un tel modèle est facultative. Si vous décidez de vous inscrire, veuillez remplir le présent formulaire (séparez-vous d’un stylo à bille encre bleue ou noire) comme suit :

• Pour vous inscrire .............................................................. remplissez les Parties 1 et 3
• Pour vous inscrire et inscrire un ou deux enfants de moins de 16 ans et/ou des adultes à charge dont vous êtes parent, tuteur légal ou procureur aux soins de la personne .................................................. remplissez les Parties 1, 2 et 3
• Pour inscrire des enfants de moins de 16 ans et/ou des adultes à charge dont vous êtes parent, tuteur légal ou procureur aux soins de la personne, mais sans vous inscrire vous-même ........................................ remplissez les Parties 2 et 3
• Pour inscrire plus de deux enfants de moins de 16 ans ou des adultes à charge dont vous êtes parent, tuteur légal ou procureur aux soins de la personne ........................................ remplissez les Parties 2 et 3 sur un formulaire distinct

Remarque : Si votre adresse postale est une case postale (CP), une route rurale (R.R.) ou la poste restante (PR), vous devez également remplir la section de l’adresse du domicile.

Si votre médecin de famille n’est pas déjà identifié ou est incorrectement à la Partie 4, veuillez écrire son nom en caractères d’imprimerie dans la case prévue à cette fin à la même Partie.

Votre médecin de famille accusera réception de votre formulaire d’inscription en remplissant la Partie 4 et il vous en remettra une copie pour vos dossiers.

Si vous avez des questions au sujet de l’inscription et du consentement, ou si vous voulez savoir comment remplir le formulaire ou obtenir des exemplaires supplémentaires, veuillez appeler la Ligne INFOLINE au 1 888 218-0929 (TTY : 1 866 367-5539).

Please see reverse for more instructions.
Veuillez consulter l’endos pour de plus amples directives.
APPENDIX B (Group Enrolment)

Patient Enrolment and Consent to Release Personal Health Information

You are being asked to enrol with a primary health care Group/Community Health Centre (Group/Centre). A primary health care group or community health centre is a group of family doctors and other health care providers who are working together to give you and your family continued access to quality primary care services.

Enrolling with a primary health care group/community health centre is your choice. If you choose to enrol, please fill out this form using a black or blue ball point pen as follows:

- To enrol yourself .......................................................... complete Sections 1 & 3
- To enrol yourself and up to two children under 16 years of age and/or dependent adults for whom you are a parent, legal guardian or attorney for personal care ........................................... complete Sections 1, 2 & 3
- To enrol children under 16 years of age and/or dependent adults for whom you are a parent, legal guardian or attorney for personal care but not yourself ... complete Sections 2 & 3
- To enrol more than two children under 16 years of age or dependent adults for whom you are a parent, legal guardian or attorney for personal care ........................................... complete Sections 2 & 3 on a separate form

Note: If the mailing address includes a post office box (P.O. Box), rural route (R.R.), or general delivery, you must also complete the residence address.

If your primary health care group/community health centre is not already identified or is incorrectly identified in Section 4, please print the name of the Group/Centre inside the box in Section 4.

Your Group/Centre will acknowledge your enrolment form in Section 4 and will provide you with a copy for your records.

For questions about enrolment and consent, filling out this form or to receive additional forms, please call INFOline at 1 888 218–9929 (TTY 1 800 387–5559).

Instructions:
1. Remove this instruction page.
2. Complete the form as instructed above.
3. Read the back of the form and Section 3 before signing and dating it.
4. Return all copies of the completed form to your Group/Centre or in the envelope provided.

(Un formulaire bilingue est également disponible. Pour en recevoir un exemplaire, composez le 1 888 218–9929)
APPENDIX B (Group Enrolment) - continued
APPENDIX B (Group Enrolment) - continued

Ontario Ministry of Health and Long-Term Care
Patient Enrolment and Consent to Release Personal Health Information
Please PRINT using black or blue ballpoint pen.

Collection of the information on this form is under the authority of the Ministry of Health Act, subsection 6(1) and (2) and the Health Insurance Act, R.S.O. 1990, c. H. 8, as amended by the Health Care Reimbursement Act, 2005, c. 2, and the Patient Health Information Protection Act, R.S.O. 1990, c. P. 46, as amended by the Health Care Reimbursement Act, 2005, c. 2.

Section 1 – I want to enrol myself with the Primary Health Care Group/Centre identified in Section 4

Last Name | First Name | Second Name
--- | --- | ---

Health Number | Version Code | Mailing Address | Apartment # | Street No. and Name or P.O. Box, Rural Route, General Delivery
--- | --- | --- | --- | ---

Date of Birth (yyyy/mm/dd) | Sex (M/F) | City/Town | Postal Code
--- | --- | --- | ---

Send notices from my family doctor’s office to me by:

[ ] regular mail
[ ] small (if possible)

Residence Address | Apartment # | Street No. and Name or Lot, Concession and Township
--- | --- | ---

City/Town | Postal Code
--- | ---

Email Address:

Section 2 – I want to enrol my child(ren) under 16 and/or dependent adult(s) with the Group/Centre identified in Section 4

A

Last Name | First Name | Second Name
--- | --- | ---

Health Number | Version Code | Mailing Address | Apartment # | Street No. and Name or P.O. Box, Rural Route, General Delivery
--- | --- | --- | --- | ---

Date of Birth (yyyy/mm/dd) | Sex (M/F) | City/Town | Postal Code
--- | --- | --- | ---

I am this person’s

[ ] parent
[ ] legal guardian
[ ] attorney for personal care

Residence Address | Apartment # | Street No. and Name or Lot, Concession and Township
--- | --- | ---

City/Town | Postal Code
--- | ---

Section 3 – Signature

I have read and agree to the Patient Commitment, the Consent to Release Personal Health Information and the Cancellation Conditions on the back of this form. I acknowledge that this Enrolment is not intended to be a legally binding contract and is not intended to give rise to any new legal obligations between my family doctor, Group/Centre and me.

I am signing on behalf of (check all that apply):

[ ] myself
[ ] child(ren)
[ ] dependent adult(s)

My Name

Signature

Date (yyyy/mm/dd)

Section 4 – Primary Health Care Group/Centre Information

Group/Centre Identification:

(Association, Locality, City, Postal Code)

Billing Number

Patient’s copy

April 2011 1-3
**APPENDIX B** (Group Enrolment) - continued

---

**Patient Enrolment and Consent to Release Personal Health Information**

*Please PRINT using black or blue ballpoint pen.*

Collected information on this form is under the authority of the Ministry of Health Act, subsection (1)(1) and (2) under section 16 of the Personal Health Information Protection Act, 2004, as set out in the Regulation and Rules (1) and (2). 16 and 17.5. For information about our privacy practices, contact the Privacy Officer,Registration and Claims Branch, Box 100, 499 University Avenue, Toronto, Ontario M5G 2Z5. (416) 326-1100. 3255 19 Avenue, Scarborough, ON, M1T 3R6 416-756-7000.

### Section 1 – I want to enrol myself with the Primary Health Care Group/Centre identified in Section 4

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Second Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Number</td>
<td>Version Code</td>
<td>Mailing Address</td>
</tr>
<tr>
<td>Date of Birth (yyyy/mm/dd)</td>
<td>Sex</td>
<td>Apartment #</td>
</tr>
<tr>
<td>City/Town</td>
<td>Street No. and Name or P.O. Box, Rural Route, General Delivery</td>
<td></td>
</tr>
<tr>
<td>Postal Code</td>
<td>Residence Address</td>
<td></td>
</tr>
<tr>
<td>Apartment #</td>
<td>Street No. and Name or Lot, Concession and Township</td>
<td></td>
</tr>
<tr>
<td>City/Town</td>
<td>Postal Code</td>
<td></td>
</tr>
<tr>
<td>Email Address:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Section 2 – I want to enrol my child(ren) under 16 and/or dependent adult(s) with the Group/Centre identified in Section 4

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Second Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Number</td>
<td>Version Code</td>
<td>Mailing Address</td>
</tr>
<tr>
<td>Date of Birth (yyyy/mm/dd)</td>
<td>Sex</td>
<td>Apartment #</td>
</tr>
<tr>
<td>City/Town</td>
<td>Street No. and Name or P.O. Box, Rural Route, General Delivery</td>
<td></td>
</tr>
<tr>
<td>Postal Code</td>
<td>Residence Address</td>
<td></td>
</tr>
<tr>
<td>Apartment #</td>
<td>Street No. and Name or Lot, Concession and Township</td>
<td></td>
</tr>
<tr>
<td>City/Town</td>
<td>Postal Code</td>
<td></td>
</tr>
<tr>
<td>I am this person’s</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>parent</td>
<td></td>
</tr>
<tr>
<td></td>
<td>legal guardian</td>
<td></td>
</tr>
<tr>
<td></td>
<td>attorney for personal care</td>
<td></td>
</tr>
</tbody>
</table>

### Section 3 – Signature

I have read and agree to the Patient Commitment, the Consent to Release Personal Health Information and the Cancellation Conditions on the back of this form. I acknowledge that this Enrolment is not intended to be a legally binding contract and is not intended to give rise to any new legal obligations between my family doctor, Group/Centre and me.

I am signing on behalf of (check all that apply):
- [ ] myself
- [ ] child(ren)
- [ ] dependent adult(s)

My Name:
- [ ] Last Name
- [ ] First Name

Signature: _____________________________

Date (yyyy/mm/dd): __________________

Section 4 – Primary Health Care Group/Centre Information

<table>
<thead>
<tr>
<th>Office use only (print)</th>
<th>Billing Number</th>
</tr>
</thead>
</table>

Physician’s copy

---
APPENDIX B (Group Enrolment) – continued

Patient Enrolment and Consent to Release Personal Health Information

Patient Commitment
I agree to contact my primary health care group/community health centre (Group/Centre), or the designated Telephone Health Advisory Service, when I, or my enrolled child(ren) or dependent adult(s), need primary care medical advice or treatment. I promise to do this unless there is an emergency or I am travelling away from home.

I agree that if I or the person(s) I have signed for move, I will contact my Group/Centre or the ministry (see box below) with a new address and telephone number.

I understand that I can end my enrolment with this Group/Centre and enrol with another primary health care group/community health centre or another family doctor after six weeks have passed from the date that I complete and sign this form (immediately if I have moved). However, I agree not to change Group/Centre or family doctor with whom I am enrolled more than twice a year.

I understand that by enrolling a child under 16 or a dependent adult, my signature on the front of this form means that I agree to these terms and conditions on behalf of that person. When an enrolled child reaches 16 years of age, the ministry will contact him or her to confirm his or her enrolment/consent with the Group/Centre.

Consent to Release Personal Health Information
I understand that my Group/Centre will be able to offer better medical care if I permit my Group/Centre and the ministry to share appropriate and relevant information relating to my health.

I agree to allow my Group/Centre and the ministry to exchange the information in this form related to my enrolment.

I agree that my Group/Centre and the ministry can exchange information about my name, address and telephone number.

I agree to allow the ministry to release the following specific information to my Group/Centre:
- dates of immunizations (flu shots, etc.)
- dates of preventive care screening services (pap tests, mammograms, etc.)
- dates of service, fees paid and fee codes of primary health care services provided to me by a primary health care group/community health centre or a family doctor outside my Group/Centre.

I agree to allow my Group/Centre and the ministry to exchange only the following information with the designated Telephone Health Advisory Service: my name, health number and version code, address, date of birth, gender.

I understand that this consent to release personal health information ends when:
- My enrolment with my Group/Centre ends or
- I cancel my consent by writing or telephoning the ministry (see box below).

The ministry will inform my Group/Centre when the consent is no longer valid. However, I understand that the information already released to my Group/Centre will remain in my medical file.

Cancellation Conditions
Enrolment with my Group/Centre and my consent to release personal health information will end when:

a) I cancel my enrolment by writing to my Group/Centre or by writing or telephoning the ministry (see box below);

b) I no longer qualify for health care services under the Health Insurance Act (Ontario);

c) the Group/Centre no longer exists;

d) I enrol with another Group/Centre or family doctor;

e) the ministry grants me an extended absence.

My enrolment with my Group/Centre and my consent to release personal health information may end when:

a) I consistently fail to meet the obligations to which I agreed in the Patient Commitment (above);

b) my family doctor leaves this Group/Centre. If this happens, I may be able to enrol with my family doctor in another Group/Centre or I may choose to continue my enrolment with this Group/Centre;

c) my family doctor chooses to discontinue acting as my family doctor in accordance with the College of Physicians and Surgeons of Ontario guidelines;

d) I become a resident of a long-term care facility;

e) I am imprisoned in a provincial or federal correctional institution; or

f) I move outside the geographic area where the Group/Centre regularly provides services.

Contact Information:
Ministry of Health and Long-Term Care
P.O. Box 48, Station Main
Kingston ON K7L 9Z9
Call: INFOLine 1 888 218–9929
TTY 1 800 367–5559

(Un formulaire bilingue est également disponible. Pour en recevoir un exemplaire, composez le 1 888 218–9929)
# APPENDIX C

## Request to Change Designated Physician Form

**Primary Health Care and Family Health Teams**  
**Group Enrolment and Consent**

Please PRINT using black or blue ball point pen.

This form
- is only for use by primary care groups who have opted for group enrolment and consent
- is only for changing the designated physician of individual patients
- must include the effective date of the change of designated physicians
- should be stamped and/or signed by both the current and new designated physicians
- should be submitted with your batch of Patient Enrolment and Consent to Release Personal Health Information forms

Each field marked by an asterisk (*) must be completed.

### Section 1 – Patient Information

<table>
<thead>
<tr>
<th>Health Number *</th>
<th>Date of Birth * (yyyy/mm/dd)</th>
<th>Sex</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Last Name *</th>
<th>First Name *</th>
<th>Middle Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Section 2 – Current Designated Physician Information

<table>
<thead>
<tr>
<th>Last Name</th>
<th>Physician Signature or Acknowledgement Stamp</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| First Name      |                                             |
|-----------------|                                             |

| Billing No.     |                                             |
|-----------------|                                             |

| Group No.       |                                             |
|-----------------|                                             |

Note: If you use your acknowledgement stamp the left side of Section 2 may be left blank.

### Section 3 – New Designated Physician Information

<table>
<thead>
<tr>
<th>Last Name</th>
<th>Physician Signature or Acknowledgement Stamp</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| First Name      |                                             |
|-----------------|                                             |

| Billing No.     |                                             |
|-----------------|                                             |

| Group No.       |                                             |
|-----------------|                                             |

<table>
<thead>
<tr>
<th>Effective Date of Change of Designated Physician * (yyyy/mm/dd)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: If you use your acknowledgement stamp the left side of Section 3 may be left blank, with the exception of the effective date.

Print Form
APPENDIX C – continued

Formulaire de demande de changement de médecin désigné
Équipes de soins primaires et de santé familiale
Adhésion et consentement (cabinet collectif)

En caractères d’IMPRIMERIE, au stylo-bille à encre noire ou bleue.
Le présent formulaire doit :
• être utilisé seulement par les groupes de soins primaires qui ont opté pour l’adhésion et le consentement de groupe
• servir uniquement à changer le médecin désigné pour un patient particulier
• inclure la date d’entrée en vigueur du changement de médecin désigné
• porter l’estampille et/ou la signature du médecin désigné actuel et du nouveau médecin désigné
• être transmis avec votre lot de Formulaires d’adhésion et de consentement à la divulgation des renseignements personnels sur la santé
Les champs obligatoires sont marqués d’un astérisque (*).

Section 1 – Renseignements sur le patient
Numéro de carte Santé *
Date de naissance * (aaaa-mm-jj)
Sexe
☐ M ☐ F
Nom *
Prénom *

Section 2 – Renseignements sur le médecin désigné actuel
Nom :
Prénom :
Numéro de facturation :
Numéro de groupe :

Nota : il n’est pas nécessaire de remplir le côté gauche de la section 2 si vous apposez votre estampille d’attestation.

Section 3 – Renseignements sur le nouveau médecin désigné
Nom :
Prénom :
Numéro de facturation :
Numéro de groupe :
Date d’entrée en vigueur du changement de médecin désigné * (aaaa-mm-jj)

Nota : si vous apposez votre estampille d’attestation, il n’est pas nécessaire de remplir le côté gauche de la section 3, à l’exception de la date d’entrée en vigueur.

4573-44 (2011/c2) Génér核查 de la Reprise (Ontario 2010)
APPENDIX D

<table>
<thead>
<tr>
<th>Section 1 - Instructions</th>
<th>Section 1 - Directives</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Complete the &quot;Primary Care Patient Enrolment Batch Header&quot; form when submitting the forms listed below to the ministry. Each batch may include a maximum of 100 forms per batch.</td>
<td>• Remplir cet En-tête de lot de formulaires d’adhésion des patients - Soins primaires au moment de présenter au ministère les formulaires indiqués ci-dessous. Chaque lot peut comprendre un maximum de 100 formulaires.</td>
</tr>
<tr>
<td>• Place the Batch Header on top of each batch of forms and mail them to the ministry by the delivery method of your choice (e.g. regular or registered mail).</td>
<td>• Placer un En-tête de lot sur le dessus de chaque lot de formulaires d’adhésion et le poster au ministère de la santé selon le mode de livraison choisi (p. ex. courrier ordinaire ou recommandé).</td>
</tr>
<tr>
<td>• Complete the information below using black or blue ball point pen.</td>
<td>• Indiquer les renseignements demandés ci-dessous à l’encre noire ou bleue.</td>
</tr>
<tr>
<td>• Send only the white (ministry) copies of the Enrolment Consent forms.</td>
<td>• Envoyer seulement les copies blanches (à la ministère) des formulaires d’adhésion et de consentement.</td>
</tr>
<tr>
<td>• Retain a copy of the batch header along with the pink copy of the Enrolment Consent forms.</td>
<td>• Garder une copie de cet En-tête de lot ainsi que la copie rose des formulaires d’adhésion et de consentement.</td>
</tr>
<tr>
<td>• Remove the tear off from the Enrolment / Consent forms prior to mailing.</td>
<td>• Retirer les étiquettes détachables des formulaires d’adhésion et de consentement avant de les envoyer.</td>
</tr>
<tr>
<td>• Ensure that all forms have been properly completed.</td>
<td>• Vérifier à ce que tous les formulaires soient adéquatement remplis.</td>
</tr>
<tr>
<td>• Mail forms to the above address.</td>
<td>• Poster les formulaires à l’adresse ci-dessus.</td>
</tr>
</tbody>
</table>

Section 2 - Batch Information / Renseignements sur le lot:

<table>
<thead>
<tr>
<th>Form type / Type de formulaire</th>
<th>No. of forms / Nombre de formulaires</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrolment / Consent forms / Adhésion et consentement</td>
<td></td>
</tr>
<tr>
<td>Request to Remove a Patient forms / Demandes de retrait d’un patient</td>
<td></td>
</tr>
<tr>
<td>Request to Change Designated Physician forms / Demande de changement de médecin désigné</td>
<td></td>
</tr>
</tbody>
</table>

Section 3 - Physician Information / Renseignements sur le médecin:

Print physician information clearly on affix address label.

Indiquer les renseignements sur le médecin en caractères d’imprimerie ou le poser sur une étiquette adresse.

<table>
<thead>
<tr>
<th>Name / Nom</th>
<th>Billing no. / N° de facturation</th>
<th>Group no. / N° de groupe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address / Adresse</td>
<td>Group name / Nom du groupe</td>
<td>Date submitted to ministry (yyyy / mm / dd)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Présenté au ministère (aaaa / mm / jj)</td>
</tr>
</tbody>
</table>

Ministry use only:

<table>
<thead>
<tr>
<th>Batch no.</th>
<th>Date received (yyyy / mm / dd)</th>
<th>No. of Health Numbers</th>
<th>Date processed (yyyy / mm / dd)</th>
<th>Clerk in charge</th>
</tr>
</thead>
</table>

April 2011
1 of 2
APPENDIX D - continued

### Section 1 - Instructions
- Complete this “Primary Care Patient Enrolment Batch Header” form when submitting the forms listed below to the ministry. Each batch may include a maximum of 100 forms per batch.
- Place the Batch Header on top of each batch of forms and mail them to the ministry by the delivery method of your choice (e.g., regular or registered mail).
- Complete the information below using black or blue ball point pen.
- Send only the white (ministry) copies of the Enrollment/Consent forms.
- Retain a copy of this batch header along with the pink copy of the Enrollment/Consent forms.
- Remove the tear offs from the Enrollment / Consent forms prior to sending.
- Ensure that all forms have been properly completed.
- Mail forms to the above address.

### Section 1 - Directives
- **En-tête de lot de formulaires d'adhésion des patients**
  - Remplir cet En-tête de lot de formulaires d'adhésion des patients. Saisis primaires au moment de présenter au ministère les formulaires indiques ci-dessous. Chaque lot peut comprendre un maximum de 100 formulaires.
  - Placer un En-tête de lot sur le dessus de chaque lot de formulaires d'adhésion et poser le tout au ministère de la modè de livraison choisie (p. ex. courrier ordinaire ou recommandé).
  - Indiquer les renseignements demandés ci-dessous à l'encre noire ou bleue.
  - Envoyer seulement les copies blanches (« Ministère ») des formulaires d'adhésion et de consentement.
  - Garder une copie de cet En-tête de lot ainsi que la copie rose des formulaires d'adhésion et de consentement.
  - Retirer les étiquettes détachables des formulaires d'adhésion et de consentement avant de les envoyer.
  - Veiller à ce que tous les formulaires soient adéquatement remplies.
  - Poster les formulaires à l'adresse ci-dessus.

### Section 2 - Batch Information / Renseignements sur le lot
**Note:** Complete a separate batch header for each of the form types listed below.
**Nota:** Remplir un En-tête de lot séparé pour chacun des types de formulaires ci-dessous.

<table>
<thead>
<tr>
<th>Form type / Type de formulaire</th>
<th>No. of forms / Nombre de formulaires</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollment / Consent forms / Adhésion et consentement</td>
<td></td>
</tr>
<tr>
<td>Request to Remove a Patient form / Demande de retrait d'un patient</td>
<td></td>
</tr>
<tr>
<td>Request to Change Designated Physician forms / Demande de changement de médecin désigné</td>
<td></td>
</tr>
</tbody>
</table>

### Section 3 - Physician Information / Renseignements sur le médecin
Print physician information clearly or affix address label. Indiquer les renseignements sur le médecin en caractères d'imprimerie ou apposer une étiquette-adresse.

<table>
<thead>
<tr>
<th>Name / Nom</th>
<th>Billing no. / N° de facturation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address / Adresse</td>
<td>Group no. / N° de groupe</td>
</tr>
<tr>
<td></td>
<td>Group name / Nom du groupe</td>
</tr>
<tr>
<td></td>
<td>Date submitted to ministry (yyyy / mm / dd)</td>
</tr>
<tr>
<td></td>
<td>Présenté au ministère (aaa/ rr / aa)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ministry use only</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>batch no.</td>
<td>Date received (yyyy / mm / dd)</td>
<td>No. of Health Numbers</td>
</tr>
</tbody>
</table>
### APPENDIX E

**Ontario Ministry of Health and Long-Term Care**

**Primary Care Request to Remove a Patient**

Collection of the information on this form is under the authority of the Ministry of Health and Long-Term Care Act, subsection 6.1(1) and (2), and the Health Insurance Act, R.S.O. 1990, c. H.6, ss.4(2)(b) and (3), 4.1(1) and (2), 10 and 15(1). For information about collection practices, contact the Director, Registration and Claims Branch, P.O. Box 48, 49 Place d’Armes, Kingston ON K7L 5R6 or by mail through your local Ministry of Health and Long-Term Care office.

Please PRINT using black or blue ball point pen. Submit this form along with your next batch of enrolment/consent forms.

---

### Section 1 – Patient Information

<table>
<thead>
<tr>
<th>Health Number / Numéro de carte Santé</th>
<th>Version Code / Code Version</th>
<th>Date of birth / Date de naissance</th>
<th>Sex / Sexe</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>M</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Last name / Nom de famille</th>
<th>First name / Prénom</th>
<th>Middle name / Second prénom</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mailing address / Adresse postale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aot. no. / App.</td>
</tr>
<tr>
<td>Street no., and name, or P.O. box number, R.R. General Delivery / N° civique et nom de rue ou C.P., R.R., poste restante</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>City / Town / Ville</th>
<th>Province</th>
<th>Postal code / Code postal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ON</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Residential address (if different from mailing address) / Adresse du domicile (si elle diffère de l’adresse postale)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apt. no. / App.</td>
</tr>
<tr>
<td>Street no., and name, or lot, concession, and township / N° civique et nom de rue ou lot, concession et canton</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>City / Town / Ville</th>
<th>Province</th>
<th>Postal code / Code postal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ON</td>
<td></td>
</tr>
</tbody>
</table>

---

### Section 2 – Removal Information

<table>
<thead>
<tr>
<th>Check / V / boite seulement / Cocher une seule case</th>
<th>Reason Code / Code Raison</th>
</tr>
</thead>
<tbody>
<tr>
<td>24 Patient added to roster in error / Nom du patient ajouté à la liste par erreur</td>
<td></td>
</tr>
<tr>
<td>40 Physician reported patient deceased / Patient décédé d’après le rapport du médecin</td>
<td></td>
</tr>
<tr>
<td>42 Patient entered Long-Term Care facility / Patient admis dans un établissement de soins de longue durée</td>
<td></td>
</tr>
<tr>
<td>44 Physician ended patient enrolment / Fin de l’admission du patient par le médecin</td>
<td></td>
</tr>
<tr>
<td>53 Patient moved out of group’s area / Le patient ne réside plus dans la zone du groupe</td>
<td></td>
</tr>
<tr>
<td>54 Patient left province / Le patient ne réside plus dans la province</td>
<td></td>
</tr>
<tr>
<td>56 Enrolment ended by physician at patient’s request / Fin de l’admission par le médecin à la demande du patient</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason for removal / Raison du retrait</th>
<th>Effective date of removal / Retrait en vigueur</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Section 3 – Physician Information**

Last name / Nom de famille

First name / Prénom

Billing no. / N° de facturation

Group no. / N° de groupe

Telephone no. / N° de téléphone

Physician signature or acknowledgement stamp / Signature du médecin ou estampille de confirmation

Queen’s Printer for Ontario, 2004

Imprimeur de la Reine pour l’Ontario, 2004

April 2011
APPENDIX F

Checklist
For a Completed Enrolment/Consent Form

- form has been signed by the patient
- the enrolment effective date is provided
- health number field is completed
- physician has acknowledged the form (signature or stamp)
- group number and physician billing number are on the form
- only one physician name should be indicated on the form
- address field is complete with current address
- patient’s health number is validated for eligibility using the Health Card Validation system (Interactive Voice Response (IVR), Overnight Batch Eligibility Checking (OBEC) or Card Swipe)

When enrolment is for a child under 16 or a dependent adult check to ensure that:

- either “parent”, “legal guardian” or “attorney for personal care” is indicated on the form
- the name of the legal guardian or attorney for personal care is included, if applicable
- the signature of either parent, legal guardian or attorney for personal care is complete
- the enrolment effective date is provided
APPENDIX F — continued

Liste de contrôle
Inscription et formulaire de consentement

✓ le formulaire est signé par le patient
✓ la date de l’inscription est indiquée
✓ champs du numéro de la carte de santé et du code sont inscrits
✓ le médecin a pris connaissance du formulaire (signature ou tampon)
✓ les numéros de groupe et de facturation du médecin sont inscrits
✓ le formulaire ne mentionne le nom que d’un seul médecin
✓ l’adresse actuelle est inscrite
✓ la validité du numéro de la carte de santé code du patient est assurée par le biais du système de validation des cartes de santé (réponse vocale interactive; Système « jour suivant » de la vérification de l’admissibilité des lots ou carte magnétique)

Lorsque l’inscription concerne un enfant de moins de 16 ans ou un adulte à charge, il faut s’assurer que :
✓ un « parent », un « tuteur » ou une « procureur au soin de la personne » est mentionné au formulaire
✓ le nom du tuteur ou du procureur au soins de la personne est indiqué, s’il y a lieu
✓ le formulaire porte la signature de l’un des parents, du tuteur ou du procureur au soin de la personne
✓ la date d’entrée en vigueur de l’inscription est mentionnée
APPENDIX G

Primary Care - Request for Information to Process Enrolment / Consent Forms

Print physician information clearly or affix address label.

Name

Address

Date:

The attached: □ Patient Enrolment and Consent to Release Personal Health Information (E/C) form
□ Request to Change Designated Physician form

is being returned to your office for the reasons outlined below. Please complete or correct the form(s) and return for processing to the ministry at the address above. If you require assistance, please call the Ministry of Health and Long-Term Care Help Desk at 1 800 262-6524 or 613 548-7881 from within the Kingston area.

□ Patient's name and health number do not match
□ Health number is required
□ Health number is not valid
□ Patient does not have OHIP eligibility
□ Patient's name is missing / does not match ministry records
□ Patient's mailing/residence address is missing
□ Patient resides outside of the group's geographic area
□ Patient resides outside of the group's geographic area, pre-member status terminated
□ Patient resides outside of the group's geographic area, patient remains assigned
□ Patient / Parent / Legal Guardian / Attorney for Personal Care signature is required
□ Delegate information is missing / illegible
□ Physician acknowledgment (stamped or signature) is required
□ Effective date of change of designated physician is missing/incorrect
□ Patient's enrolment effective date is missing / incorrect
□ More than one group / physician's information indicated on the form
□ Patient is not a minor/dependent adult; please have him / her complete and sign a separate form.
□ Patient is not in compliance with the Patient Commitment section as described on the reverse of the E/C form
□ Form must be completed using black / blue ballpoint pen for microfilming purposes
□ Original white "ministry" copy of the E/C form must be submitted
□ Pink "Physician" copy of the E/C form must be retained in the physician's office
□ Unattached Patient Declaration form must be retained in the physician's office per the agreement.
□ Other (specify)

This information is intended only for the person or entity to which it is addressed and may contain confidential and/or privileged material. Any review, retransmission, forwarding, dissemination or other use, or taking of any action in reliance upon this information by any person, or entities other than the intended recipient, is prohibited.

If you received this in error, please return to the following address: Ministry of Health and Long-Term Care, Enrolment Processing Unit, PO Box 48, Kingston ON, K7L 5J3.

April 2011
Indiquez les renseignements sur le médecin en caractères d'imprimerie ou appelez une étiquette-adresse.

Nom:

Adresse:

Le formulaire joint

☐ Formule d'adhésion et de consentement à la divulgation des renseignements personnels sur la santé
☐ Formulaire de demande de changement de médecin désigné

Vous est retourné pour la ou les raisons ci-dessous. Veuillez remplir ou corriger le ou les formulaires et le retourner pour traitement au ministère à l'adresse ci-dessus. Pour obtenir de l'aide, appelez le service d'assistance au ministère de la Santé et des Soins de longue-duree au 1 800 262-8524, ou au 613 548-7961 si vousappelez de la région de Kingston.

☐ Le nom du patient et son numéro de carte Santé ne correspondent pas
☐ Le numéro de carte Santé est requis
☐ Le numéro de carte Santé n'est pas valide
☐ Le patient n'est pas assuré à l'Assurance-santé
☐ Le nom du patient a été omis ou ne correspond pas aux dossiers du ministère
☐ L'adresse postale ou résidentielle du patient a été omise
☐ Le patient réside en dehors de la zone géographique du groupe
☐ Le patient réside en dehors de la zone géographique du groupe, son statut de membre temporaire est expired
☐ Le patient réside en dehors de la zone géographique du groupe, il continue d'avoir un médecin désigné
☐ La signature du patient / parent / tuteur légal / mandataire pour soins personnels est requise
☐ Les renseignements sur le représentant ont été omis ou sont illisibles
☐ L'attestation (estampille ou signature) du médecin est requise
☐ La date d'entrée en vigueur du changement du médecin désigné a été omise ou est incorrecte
☐ La date d'entrée en vigueur de l'adhésion du patient a été omise ou est incorrecte

Des renseignements concernant plus d'un groupe ou médecin ont été indiqués sur le formulaire.

☐ Le patient est majeur ou il n'est pas un adulte à charge il doit remplir et signer un formulaire distinct.
☐ Le patient ne se conforme pas à la section sur l'engagement du patient décrit au verso du formulaire d'adhésion et de consentement.
☐ Il faut que le formulaire soit rempli avec un stylo-bille à encres noire ou bleue pour le microfilmage
☐ Il faut présenter la copie blanche « Ministère » du formulaire d'adhésion et de consentement.
☐ Il faut conserver la copie rose « Médecin » du formulaire d'adhésion et de consentement au cabinet du médecin.
☐ Il faut conserver le formulaire Déclaration de patient orphelin au cabinet du médecin en vertu de l'entente.
☐ Autre (précisez)
APPENDIX H

Primary Care Request for Information to Remove a Patient

The ministry is unable to process the attached Request to Remove a Patient form. It is being returned to your office for the following reason(s).

☐ Physician signature/acknowledgement is required
☐ Health number is required
☐ Health number is not valid
☐ Effective date is required
☐ Patient is not enrolled with you
☐ Other (specify)

Please complete or correct the form and attach it to this notice. The corrected form and this notice can be submitted to the ministry together with your next batch of enrolment/consent forms.

If you require assistance, please call the Ministry of Health and Long-Term Care Help Desk at 1 800 262-6524 or 613 458-7561 from within the Kingston area.

This information is intended only for the person or entity to which it is addressed and may contain confidential and/or privileged material. Any review, retransmission, forwarding, dissemination or other use of, or taking of any action in reliance upon this information by any person, or entities other than the intended recipient, is prohibited. If you received this in error, please return to the following address: Ministry of Health and Long-Term Care, 1055 Princess St. Suite 201, Kingston ON K7L 5T3.

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Soins primaires Demande d’information relativement au retrait d’un patient

Le ministère ne peut traiter le formulaire Demande de retrait d’un patient ci-joint pour une ou plusieurs des raisons suivantes.

☐ Signature ou confirmation du médecin requise
☐ Numéro de carte Santé requis
☐ Numéro de carte Santé non valide
☐ Date en vigueur requise
☐ Patient non inscrit auprès de vous
☐ Autre ( précisez )

Veuillez remplir ou corriger le formulaire et le joindre à cet avis. Vous pouvez faire parvenir le formulaire corrigé et le présent avis au ministère en même temps que votre prochain lot de formulaires d’adhésion et de consentement.

Si vous avez besoin d’aide, vous pouvez appeler le Service d’assistance du ministère de la Santé et des Soins de longue durée au 1 800 262-6524 ou, si vous êtes de la région de Kingston, au 613 548-7561.

Ce document est destiné uniquement à la personne ou à l’entité à laquelle il est adressé, et peut contenir des renseignements confidentiels ou protégés par le secret professionnel. L’examen, la retransmission, la divulgation, la distribution ou toute autre utilisation de ces renseignements, ou toute action entreprise en fonction de ceux-ci, par tout particulier ou toute entité autre que la personne à qui ce document est destiné, sont strictement interdits. Si vous avez reçu ce document par erreur, veuillez le retourner à l’adresse suivante : Ministère de la Santé et des Soins de longue durée, 1055, rue Princess, bureau 201, Kingston ON K7L 5T3.
APPENDIX I

What’s your address?

Has it changed since you got your Health Card?

Quelle est votre adresse?

A-t-elle changé depuis la réception de votre carte Santé?

MOVING?

Don’t take risks with your health coverage.

Complete this form and return to:
ServiceOntario
PO Box 48
Kingston ON K7L 5J3

1. Fill in your new address and the date of move.
2. Provide a telephone number where you may be reached during the day for more information.
3. Complete for everyone moving to the same address. Each person must sign as declaration that the information is true and accurate. (Parent/guardian may sign for children under 16).

Failure to notify ServiceOntario may affect your health coverage.

VOUS DEMÉNAGEZ?

Ne prenez pas de risques touchant votre protection.
Veuillez compléter cette formule et la retourner :
ServiceOntario
CP 48
Kingston ON K7L 5J3

1. Inscrivez votre nouvelle adresse et la date du déménagement.
2. Inscrivez un numéro de téléphone où l’on peut vous rejoindre durant la journée pour plus de renseignements.
3. Remplissez cette section pour chaque personne qui déménage à cette même adresse. Chaque personne inscrite doit y apporter sa signature à titre de déclaration que l’information inscrite est exacte et vérifiable (un parent ou tuteur peut signer pour les enfants en bas de 16 ans).

La couverture de l’Assurance-santé peut être interrompue si vous n’avisez pas ServiceOntario.
## Change of Address

**Change of Address**

1. **New Mailing Address / Nouvelle adresse postale**
   - **Apt. / App:**
   - **Street no. & name, R.R., P.O. Box, General delivery / N° et nom de la rue, R.R., C.P., poste restante**
   - **City / Ville:**
   - **Province / Pays:**
   - **Postal Code / Code postal:**
   - **Date of move / Date du déménagement:**

2. **Telephone**
   - **Telephone (home) / Téléphone (domicile):**
   - **Telephone (business) / Téléphone (bureau):**
   - **Ext:**

3. **Who is moving? / Qui déménage?**
   - **Last name / Nom de famille:**
   - **Health Number / Numéro de carte Santé:**
   - **Date of birth / Date de naissance:**
   - **Signature:**

   **Person 2 / Personne 2**
   - **Last name / Nom de famille:**
   - **Health Number / Numéro de carte Santé:**
   - **Date of birth / Date de naissance:**
   - **Signature:**

   **Person 3 / Personne 3**
   - **Last name / Nom de famille:**
   - **Health Number / Numéro de carte Santé:**
   - **Date of birth / Date de naissance:**
   - **Signature:**

   **Person 4 / Personne 4**
   - **Last name / Nom de famille:**
   - **Health Number / Numéro de carte Santé:**
   - **Date of birth / Date de naissance:**
   - **Signature:**

---

Collection of the personal health information on this form is for assessment and verification of eligibility for Ontario health insurance coverage, or related programs, health planning and research, and the administration of the Health Insurance Act and Ontario Drug Benefit Act. The authority for the collection and use of this information is found in the Personal Health Information Protection Act, R.S.O. 2004, c. H.14, s. 2(3) and 4.1(1) and (2) and the Ontario Drug Benefit Act, R.S.O. 1990, c. O. 10, s 13 (1) and (2). The information may be used and disclosed in accordance with the Ministry of Health and Long-Term Care’s Statement of Information Practices which may be accessed at www.health.gov.on.ca. I understand that I may withhold consent to the collection of this information, however, this may interfere with the provision of my Ontario health insurance coverage. For information about collection practices, call 1 800 283-1154 or write to the Director, Registration and Claims Branch, PO Box 48, 4th Floor, 49 Place d’Armes, Kingston ON K7L 5J3.

APPENDIX J

Ontario Ministry of Health and Long-Term Care Ministère de la Santé et des Soins de longue durée

Request for Primary Health Care Enrolment Material

Mail or fax the completed form to:
DATA Group of Companies
Primary Care Project
9195 Torbram Road
Brampton ON L6S 6H2
Tel: 1 800 380-1789
Fax: 1 888 234-1365
Email: primarycare@datagroup.ca

Print Clearly

**Physician Information** (to be imprinted on the enrolment / consent form)

<table>
<thead>
<tr>
<th>First Name</th>
<th>Last Name</th>
<th>Group Type (e.g., PHN, FHs, FMC)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Name of Primary Care Group:

Shipping Address

<table>
<thead>
<tr>
<th>Unit No.</th>
<th>Street No.</th>
<th>Street Name</th>
<th>City/Town</th>
<th>Postal Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Contact Name (First Name, Last Name)

<table>
<thead>
<tr>
<th>Telephone No.</th>
<th>Extension</th>
<th>Fax No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

☑ Imprint above address on the enrolment forms along with physician’s name. If different address is to be imprinted, please attach on a separate sheet.

Indicate items being requested

<table>
<thead>
<tr>
<th>Item Description</th>
<th>English</th>
<th>Bilingual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrolment / Consent forms imprinted with</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Physician Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Group Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Both Physician and Group Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Enrolment Kits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Reminder Post Cards (to be mailed out to patients to follow-up on enrolment kits)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Business Reply Envelopes (to be used only for patients to return completed forms)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Patient Information Brochures are available in any of the following languages. Please specify language and quantity:

<table>
<thead>
<tr>
<th>Language</th>
<th>Quantity</th>
<th>Language</th>
<th>Quantity</th>
<th>Language</th>
<th>Quantity</th>
<th>Language</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arabic</td>
<td>Tarsi</td>
<td>Korean</td>
<td>Tamil</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chinese</td>
<td>simplified</td>
<td>French</td>
<td>Polish</td>
<td>Ukrainian</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>traditional</td>
<td>Greek</td>
<td>Portuguese</td>
<td>Urdu</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Croatian</td>
<td>hindi</td>
<td>Punjabi</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>English</td>
<td>Italian</td>
<td>Spanish</td>
<td>Braille</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Order Confirmation

Group Registration No. (e.g., FXXX/BXXX) | Order Placed by | Date (yyyy/mm/dd)
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

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Request for Primary Health Care Enrolment Material

for Comprehensive Care Model (CCM) Physicians - Group ID N000 Only

Mail or fax the completed form to:
DATA Group of Companies
Primary Care Project
9195 Torbram Road
Brampton ON L6S 6H2
Tel: 1 800 380-1789
Fax: 1 888 234-1365
Email: primarycare@datagroup.ca

Print Clearly.

Physician Information (to be imprinted on the enrolment / consent form)
First Name | Last Name

Shipping Address
Unit No | Street No | Street Name | City/Town | Postal Code
Contact Name (First Name, Last Name) | Email Address
Telephone No
Extension | Fax No.

☐ Imprint address on the enrolment forms along with physician’s name. If different address is to be imprinted, please attach on a separate sheet.

<table>
<thead>
<tr>
<th>Indicated items being requested</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrolment / Consent forms imprinted with</td>
<td>English</td>
</tr>
<tr>
<td>☐ Physician Name:</td>
<td></td>
</tr>
<tr>
<td>☐ Physician Name with Address:</td>
<td></td>
</tr>
<tr>
<td>☐ Enrolment Kits</td>
<td></td>
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<tr>
<td>☐ Bilingual Kits - include Bilingual Enrolment/Consent form, both English and French Patient Fact Sheets, CCM Invitational letter and Business Reply Envelope</td>
<td></td>
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<tr>
<td>☐ Reminder Post Cards (to be mailed out to patients to follow-up on enrolment kits)</td>
<td></td>
</tr>
<tr>
<td>☐ Business Reply Envelopes (only to be used for patients to return completed forms)</td>
<td></td>
</tr>
<tr>
<td>☐ CCM Invitational Letters and Patient Fact Sheets</td>
<td></td>
</tr>
</tbody>
</table>

Order Confirmation
Model Registration No. | Order Placed by | Date (yyyy/mm/dd)
M000 | X | 

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April 2011 1-1