

# andrew st

family health centre

16 Andrew St, Kitchener ON N2H 5R2  
phone: 519.804.9234

fax 519.804.2604

Dr. \_\_\_\_\_  
16 Andrew Street  
Kitchener, Ontario N2H 5R2  
Tel: 519-804-9234  
Fax:

Date \_\_\_\_\_

To: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Dear Doctor:

I have chosen Dr. \_\_\_\_\_ as my new family physician. Please forward to the above address a summary of my chart and copies of any helpful reports you may have on file.

I understand that this service is not covered by OHIP. I realize that there is a charge for this service and that I am responsible for it. Please forward the bill for the service of preparing this report to me for my prompt attention. Thank you.

## PLEASE PRINT

Name: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of Birth \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone # \_\_\_\_\_

Patient Signature \_\_\_\_\_

Substitute Decision Maker: \_\_\_\_\_  
(print-in block letters) (signature)

\_\_\_\_\_  
(relationship to patient)