Ontario Health
Cancer Care Ontario

Physician Registration for Patient Attachment

Upon completion, please fax or email this form to: 416-971-6888 or cancerinfo@ontariohealth.ca.

As part of the ColonCancerCheck program, unattached patients (those without a primary care provider) can be screened for colon cancer, for example, by contacting Telehealth Ontario. Unattached patients with an abnormal result need to connect with a primary care provider for appropriate follow-up. By providing the information below, you are indicating you are willing to accept new patients to your primary care practice from the ColonCancerCheck program as of the date of form completion. You can remove your name from the referral list at any time by calling 1-866-662-9233. Please note, if you are a patient enrolment model (PEM) physician and you roster patients referred from Ontario Health (Cancer Care Ontario) to your practice, you can claim the Q043A New Patient Fee, for FOBT Positive/ Colorectal Cancer Increased Risk.

Personal information on this form, such as sex, is collected under the authority of the Cancer Act and will be used to attach patients to you. Questions about this collection should be directed to Primarycareinquiries@ontariohealth.ca

Asterisk (*) indicates mandatory fields

***Physician's First Name:** ***Physician's Last Name:**

***Sex:** ☐ Male ☐ Female ***Languages Served:** ☐ English ☐ French ☐Other:

Billing Number: **CPSO Number:**

Organization Name:

Practice Model Type:

- ☐ Community Health Centre
- ☐ Family Health Group
- ☐ Family Health Network
- ☐ Family Health Organization
- ☐ Rural Northern Physician Group Agreement
- ☐ Comprehensive Care Model
- ☐ Non-PEM Primary Care Provider
- ☐ Other

Please include the requested information for all locations from which you practice and are willing to accept new patients as part of the ColonCancerCheck program.

Practice Location #1

*Address Line 1:
*Address Line 2:
*City:
*Prov: ON
*Postal Code:
*Phone Number:
*Fax Number:
Email Address:

Practice Location #2

*Address Line 1:
*Address Line 2:
*City:
*Prov: ON
*Postal Code:
*Phone Number:
*Fax Number:
Email Address:

***Physician Signature:** ***Date:**