Physician Survey

ColonCancerCheck

Upon completion, please fax this survey to: 416-971-6888

As part of the ColonCancerCheck program unattached patients (those without a family physician) will be able to be screened for colorectal cancer. By providing the information below, you are indicating that you are willing to accept new patients from the program as of the date of survey completion. You can remove your name from the referral list at any time by calling 1-866-662-9233

Asterisk (*) indicates mandatory fields. PLEASE PRINT LEGIBLY.

*Name: _____ _____ _____
First Middle Last

*Gender: ☐ Male ☐ Female

*Languages Served: ☐ English ☐ French ☐ Other(s) (specify): _____

Optional to include one of either: Billing Number _____

CPSO Number _____

Organization Name: _____

Patient Enrolment Model (PEM) Type:

- ☐ Community Health Centre
- ☐ Family Health Group
- ☐ Family Health Network
- ☐ Other PEM (specify): _____
- ☐ Family Health Organization
- ☐ Rural Northern Physician Group Agreement
- ☐ Comprehensive Care Model
- ☐ Not Applicable

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's Signature Date

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