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Pacific Centre Family Services Association

APPLICATION FOR PRIMARY CARE PROVIDER

Please submit this application to chcintake@pcfsa.org or by fax to 250-480-7335

ABOUT THE WESTSHORE COMMUNITY HEALTH CENTRE AT PCFSA

The Westshore Community Health Centre provides primary care services delivered by a doctor or nurse practitioner plus additional care from a large healthcare team who support physical, social, and emotional wellbeing. **The clinic's mandate is to serve those in the Westshore (Langford/Highlands, Colwood, Metchosin) who are experiencing barriers to care and do not have a regular healthcare provider.**

DATE _____ **PERSONAL HEALTH NUMBER:** _____

REFERRAL SOURCE

☐ Self/on behalf of dependent (contact will only be with applicant or parent/guardian)

☐ Agency Provider/Professional (submitting on behalf of client)

Name: Agency/Clinic:

Phone: Email:

Did the applicant consent to the referral (we will only contact applicants with their consent): ☐ YES ☐ NO

CONTACT INFORMATION

Applicant Name: _____ Date of Birth (month/day/year): _____

Preferred Name: _____ Gender _____ Prefer not to answer ☐

Sex Assigned at Birth: ☐ Female ☐ Male ☐ Other: _____ Prefer not to answer ☐

Pronouns: _____

If you are applying for a dependent, parent/guardian name: _____

Home Address: _____

☐Live Alone ☐Live with Others ☐Stable Housing ☐Unstable Housing ☐Homeless (includes shelter and couch surfing)

Phone: _____ **Alt. Phone:** _____ **Email:** _____

Preferred Method of Contact: ☐ Phone ☐ Email ☐ Outreach (please indicate where): _____

Any particular communication needs (please note we are unable to text): _____

To help us understand your health resources, do you identify as Indigenous?

☐ First Nations ☐ Metis ☐ Inuit ☐ Non-Status First Nations

Indigenous Community Name: _____

Are any of the applicant's family members currently a client of PCFSA? ☐ **Yes** ☐ **No**

If yes, please list name(s)/relationship to applicant:

_____

Is the applicant requesting support for any other family members? ☐ **Yes** ☐ **No**

If yes, fill out a separate form for each family member and list names of other family member applying:

_____

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HEALTH NEEDS

What are the applicant's urgent health concerns (please include as much detail as possible):

Does the applicant currently have a General Practitioner? If yes, why are they wanting to switch primary care providers?

BARRIERS

Barriers to accessing a regular healthcare provider? (check all that apply)

☐ Have no one to rely on for help
☐ Lack of Stable/Adequate Housing
☐ Struggling or unable to make ends meet at the end of the month
☐ Discrimination based on culture, race, gender identity, sexual orientation, or other
☐ Other:_____

MEDICAL INFORMATION

Does the applicant have any of the following medical conditions? (check all that apply)

☐ Chronic Disease (Diabetes, Heart Disease, Lung Disease, etc.)
☐ Infectious Disease (HIV, Hepatitis C, etc.)
☐ Developmental Disability (Autism, Cerebral Palsy, etc.)
☐ Mobility Impairment (Wheelchair, Walker, etc.)
☐ Substance-Use Struggles (Alcohol, Opioids, Stimulants, etc.)
☐ Mental Health Conditions Impacting Function (Relationships, Works, etc.)
☐ Other: _____
☐ Sensory Impairment (Vision or Hearing Loss, etc.)
☐ Chronic Pain
☐ Frail elderly
☐ In need of end-of-life/palliative care

Is the applicant seeking any of the following services:

☐ Gender Affirming Care (hormone therapy, gender affirming surgery, general gender affirming medical care)
☐ Substance-Use Services (including Opioid Agonist Therapy)
☐ Access to an Indigenous Health Care Liaison as part of their primary care services (for Indigenous identifying applicants)

PLEASE REVIEW INFO BELOW BEFORE SUBMITTING:

We are limited by the capacity of our primary care providers. As space allows, we will follow up with the applicant/their designate directly only if they are identified as meeting the organization's mandate, which is to serve individuals located in the West Shore communities who are experiencing significant barriers to care. **Completing an application does not guarantee attachment to a family doctor/nurse practitioner at the Westshore Community Health Centre.** By checking this box, you acknowledge that you have reviewed this information and/or shared it with the applicant you are supporting: ☐

We encourage everyone to also register with the Health Connect Registry by calling 811 or online at:

https://www.healthlinkbc.ca/health-connect-registry

PCFSA CONTACT INFORMATION:
Phone: 250-478-8357 **Toll Free:** 1-866-478-8357
Email: chcintake@pcfsa.org **Website:** https://pacificcentrefamilyservices.org/
Address: 200-324 Goldstream Avenue, Langford, BC V9B 2W3