Contact Information Form

Please attach this form to your signed Consent Form and mail both documents to us in the self-addressed stamped envelope provided. All information mailed to us will be kept in a secure location and only used by clinical members of the POCP team.

First Name	
Last Name	
Date of Birth (*DD/MM/YY*)	
POCP User name	
Phone# 1	
Phone #2	
Name of your family doctor	
Clinic name	
Clinic address	
Clinic phone#	
Health card (OHIP) #	

Please contact us by phone or email if you have any questions. Please note that communication via e-mail is not absolutely secure. Please do not communicate personal sensitive information via e-mail.

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