



PATIENT WAITLIST REQUEST FORM

Important Notice: If you are not already a TLC Medical patient, please scan the QR code to create a Quipo Health account at tlcmedical.ca before submitting this form.

Please indicate your preference for being waitlisted for:

Family Physician [] Nurse Practitioner []

By submitting this form, you agree to be waitlisted for a primary care provider at your selected TLC Medical Clinic listed below.

- TLC HIGHGATE - 250-7155 Kingsway, Burnaby, BC, V5E 2V1 ~ Email: highgate@tlcmedical.ca
TLC GRANVILLE - 1519 West 57th Avenue, Vancouver, BC, V6P 0C8 ~ Email: granville@tlcmedical.ca
TLC KNIGHT ST - 1418 41st Avenue East, Vancouver, BC V5P 1J7 ~ Email: knight@tlcmedical.ca
TLC SE MARINE DRIVE - 725 SE Marine Drive ,Vancouver,BC,V5X 2T9 ~ Email: marine@tlcmedical.ca
TLC RICHMOND - 8120 Cook Rd #120, Richmond, BC V6Y 1T9, Canada ~ Email: richmond@tlcmedical.ca
TLC SURREY - 150-13655 Fraser Hwy , Surrey, BC V3T 0P8 ~ Email: surrey@tlcmedical.ca
TLC MISSION - 201-32818 7th Ave, Mission, BC V2V 2C3 ~ Email: mission@tlcmedical.ca
TLC NORTH VANCOUVER - 102-1200 Lonsdale Ave, North Vancouver, BC V7M 3H6 ~ Email: northvan@tlcmedical.ca
TLC FRASER ST - 3905 Fraser St, Vancouver, BC V5V 4ES ~ Email: fraser@tlcmedical.ca

PATIENT INFORMATION

Form with fields for Patient Information: First Name, Last Name, Date of Birth, Gender, Preferred Pronoun, Care Card Number, Address, City, Province, Postal Code, Email, Cell Phone, Home Phone, Work Phone, Marital Status, Occupation, Employer, Emergency Contact, Previous Primary Care Provider, Reason for Transfer, Clinic Name, Spoken Languages.

ALLERGIES

List any known allergies to medications, foods, or environmental factors. Include the type of reaction : rash, swelling, anaphylaxis, etc.

Allergy	Reaction	Allergy	Reaction

PREVIOUS MEDICAL HISTORY

List any medical conditions you have been diagnosed with (e.g., Diabetes, Hypertension, Asthma, etc.) along with year of diagnosis. Additionally, indicate if you are under the care of a specialist and include the specialist's name, if applicable.

Year of Diagnosis	Medical Conditions	Specialist Name

PREVIOUS SURGICAL/ HOSPITALIZATION HISTORY

Date/ Year	List any previous surgeries or hospitalization, including the reason, the year they occurred, and any complications, if applicable.

FAMILY HISTORY

Please indicate any family history of chronic or significant illness (e.g., diabetes, cancer, mental health disorders) and relationship to you.

Father:		Siblings:	
Mother:		Children or Others:	

HEALTH MAINTENANCE

Please indicate the month and year of your most recent check-up, if applicable

Eye Exam:	Dental Exam:	Colonoscopy/ FIT:	Bone Density:

MEDICATIONS

List all current medications, including prescription medications, over-the-counter products, supplements, vitamins, and herbal or natural remedies.

Name	Dosage / Frequency	Name	Dosage / Frequency

SOCIAL HISTORY

Alcohol :	How much/day:	Tobacco:	How much/day:	Caffeine:	How much/day:
Sleep:	How much/day:	Drug use:	How much/day:		
			What Drugs:		
Exercise:	How Often:				
	Activities:				

REPRODUCTIVE: (FEMALES ONLY)

Please indicate the month and year of your most recent check-up, if applicable:

Number of pregnancies:	List of outcomes of each pregnancies with year (e.g., 2010):		
Date of last pap smear:	Please tick:	Normal	Abnormal
		<input type="checkbox"/>	<input type="checkbox"/>
Date of last mammogram:	Please tick:	Normal	Abnormal
		<input type="checkbox"/>	<input type="checkbox"/>

Please read carefully before dating and signing at the bottom.

Waitlist Agreement :

By submitting this form, you agree to be indefinitely waitlisted for a primary care provider at your selected TLC Medical Clinic. You acknowledge and consent to be contacted via email or telephone by our office, once you are matched with a primary care provider who is accepting new patients at your chosen clinic.

Disclaimer Notice :

Completion of the new patient online registration at Quipo Health, along with this waitlist intake form, constitutes acknowledgment that Total Life Care makes no guarantees regarding the availability of a primary care provider and cannot provide a defined timeline for contact by the selected TLC Medical Clinic.

Consent to Collect and Use Personal Information:

I consent to the collection, use and disclosure of my personal health information by Total Life Care for providing healthcare, billing, and as required by law. My information may be shared with healthcare providers involved in my care.

Electronic Communication Consent:

I consent to receive communication via email, SMS, or other electronic means from Total Life Care for appointments and healthcare information, understanding the risks involved.

Consent for Minors (if applicable):

As the parent/ guardian, I consent to medical care and use of my child's personal health information.

Right to Withdraw Consent:

I understand that consent may be withdrawn at any time by submitting written notice to Total Life Care via the email address of the TLC Medical Clinic location to which this form was submitted.

Patient/ Guardian Name:	Relationship to Patient:
Date (DD/MM/YYYY):	Patient/ Guardian Signature

Kindly submit/email the completed form to your designated TLC Medical Clinic location for processing.
We sincerely thank you for taking the time to complete this form.

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