DT9164

REGISTRATION FORM FOR THE LIST OF ACCESS TO SPECIALIZED AND ULTRASPECIALIZED MEDICAL SERVICES

The date on which this form is received by the person in charge of the central management mechanism for access to services of the institution, and the entry of data in the system set off the calculation of the waiting time for the service indicated below. This form does not replace the Proposed Operation form or the Services Booking form, which must also be enclosed herewith.

Information on Patient — Section to fill out if no Addressograph Machine *(in block letters)*

Surname	Given name(s)	Sex: ☐ Male ☐ Female
Date of birth — Year / Month / Day	Mother's surname at birth	
Health insurance number	Date of expiry	File no.
Address		Postal code
Telephone number — Area code Home	Area code Work / Ext.	Other

Section for Physician

Physician's name *(in block letters)*	Specialty

Type of specialized service required: *(must be consistent with the Proposed Operation form or the Services Booking form)*

Medical priority upon registration: *(check the corresponding level)*

For a hip, knee, or cataract: ☐ ≤ 6 months

For all other operations: ☐ ≤ 3 months ☐ ≤ 6 months ☐ ≤ 9 months ☐ ≤ 12 months ☐ ≤ 18 months

I am registering the patient on the list of access to specialized and ULTRASPECIALIZED MEDICAL SERVICES for the type of service indicated above. I am enclosing herewith a Proposed Operation form or the Services Booking form.

Physician's signature	Licence no.	**Date**	Year / Month / Day

Section for Patient

By signing below, I understand that I will be registered on the list for access to services of the institution named below with the goal of obtaining the specialized service indicated in the "Section for Physician".

Signature of Patient or his/her legal representative	**Date**	Year / Month / Day

☐ Incapacity to sign ☐ Other (specify)

Receipt of the application form by the person in charge of the central management mechanism for access to services of the institution

Name of the institution	Institution code

Signature of the person authorized to process this application	**Date of receipt of the application at the institution**	Year / Month / Day
Foreseeable date for obtaining the specialized service to be disclosed to the patient		Year / Month / Day

Return the form to the institution at your earliest convenience