Ontario Cessation Care Form

Applicant	
Last name:	Name:
Health insurance number (RAMQ):	Expiration date:
Date of birth:	Phone number:
Preferred language:	

Medical services
1. What is the primary health condition for which you are being treated in Ontario?
2. How often are you treated for this condition?
3. What is the nature of the care you are receiving?
4. Expected date of your next follow-up:
5. Date your care in Ontario ended:

Note: Please attach the doctor's termination of care letter to this form, if applicable.

Specialist doctor	
Last name:	Doctor's speciality:
Name:	Practice location:

Consent		
Do you consent to receive care in Québec?	Yes ☐	No ☐

Note: if you answered yes to the question, ask your doctor for a copy of your medical record.

Send this form and your medical file to: **transfertmedtk@ssss.gouv.qc.ca** or bring them to the reception desk of the Témiscaming-Kipawa Health Center. For support, call 819 627-3385, ext. 0.

Centre intégré de santé et de services sociaux de l'Abitibi-Témiscamingue

Québec