

INTAKE FORM:

All Information Is Confidential

The information requested allows Women's Health in Women's Hands to evaluate each applicant for eligibility for our services; therefore, we request you complete this document in its entirety. Not filling out the form in its entirety will delay the review process.

Do not send this form through fax or email, it will not be accepted. Do not attach your medical chart to the application, it will not be accepted.

If you are applying for a primary care provider, please note you cannot have a primary care provider at a different clinic at the same time.



2 Carlton Street Suite 500
Toronto ON
M5B 1J3
Tel: 416-593-7655

Date: _____

Name

Last name: _____

Preferred name: _____

First name: _____

Middle names: _____

Birthdate: _____ (day/month/year)

1. What is your gender? Check ONE only

- 1. Female
- 2. Intersex
- 3. Male
- 4. Trans-Female to Male
- 5. Trans-Male to Female
- 6. Two-Spirit
- 7. Other (Please specify): _____
- 98. Do not know
- 99. Prefer not to answer

2. Address

Street/Apartment #: _____

City/Postal Code: _____

3. Can you receive mail at the above address? Yes No

4. Telephone

Primary: _____ Alternate: _____

Can we leave a voice mail at the number(s) provided? Yes No

5. If we cannot phone or write, how can we reach you?

Please explain: _____

6. Health Insurance Coverage:

Interim Federal Health (IFH) program OHIP Other: _____

Health Insurance #: _____ Version code (if applicable): _____

7. Do you reside in Canada? Yes No

8. Primary Care Provider (e.g. family doctor, nurse practitioner etc.) _____

Name: _____ Telephone: _____

Address: _____

9. If you currently have a primary care provider do you wish to transfer you care? Yes No

10. Are you receiving service at another Community Health Centre? Yes No

If yes, which one and what services are you receiving?

Name of Community Health Centre: _____ **Service(s):** _____

11. Which of the following best describes your racial or ethnic group? Check ONE only

- 1. Asian-East (e.g., Chinese, Japanese, Korean)
- 2. Asian-South (e.g., Indian, Pakistani, Sri Lankan)
- 3. Asian-South East (e.g., Malaysian, Filipino, Vietnamese)
- 4. Black-African (e.g., Ghanaian, Kenyan, Somali)
- 5. Black-Caribbean (e.g., Barbadian, Jamaican)
- 6. Black-North American (e.g., Canadian, American)
- 7. First Nations
- 8. Indian-Caribbean (e.g., Guyanese with origins in India)
- 9. Indigenous | Aboriginal *not included elsewhere*
- 10. Inuit
- 11. Latin American (e.g., Argentinian, Chilean, Salvadoran)
- 12. Metis
- 13. Middle Eastern (e.g. Egyptian, Iranian, Lebanese)
- 14. White-European (English, Italian, Portuguese, Russian)

- 15. White-North American (e.g., Canadian, American)
- 16. Mixed heritage (e.g., Black-African & White-North American)
Please specify: _____
- 17. Other(s)
Please specify: _____
- 98. Do not know
- 99. Prefer not to answer



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Name _____

12. What language would you feel most comfortable speaking in with your health care provider? Check ONE

- | | |
|--|---|
| <input type="radio"/> 1. Amharic | <input type="radio"/> 19. Polish |
| <input type="radio"/> 2. Arabic | <input type="radio"/> 20. Portuguese |
| <input type="radio"/> 3. ASL | <input type="radio"/> 21. Punjabi |
| <input type="radio"/> 4. Bengali | <input type="radio"/> 22. Russian |
| <input type="radio"/> 5. Chinese (Cantonese) | <input type="radio"/> 23. Serbian |
| <input type="radio"/> 6. Chinese (Mandarin) | <input type="radio"/> 24. Slovak |
| <input type="radio"/> 7. Czech | <input type="radio"/> 25. Somali |
| <input type="radio"/> 8. Dari | <input type="radio"/> 26. Spanish |
| <input type="radio"/> 9. English | <input type="radio"/> 27. Tagalog |
| <input type="radio"/> 10. Farsi | <input type="radio"/> 28. Tamil |
| <input type="radio"/> 11. French | <input type="radio"/> 29. Tigrinya |
| <input type="radio"/> 12. Greek | <input type="radio"/> 30. Turkish |
| <input type="radio"/> 13. Hindi | <input type="radio"/> 31. Twi |
| <input type="radio"/> 14. Hungarian | <input type="radio"/> 32. Ukrainian |
| <input type="radio"/> 15. Italian | <input type="radio"/> 33. Urdu |
| <input type="radio"/> 16. Karen | <input type="radio"/> 34. Vietnamese |
| <input type="radio"/> 17. Korean | <input type="radio"/> 35. Other (please specify): _____ |
| <input type="radio"/> 18. Nepali | <input type="radio"/> 98. Do not know |
| | <input type="radio"/> 99. Prefer not to answer |

13. Do you need a cultural interpreter?

- Yes No Language (including ASL, dialect): _____

14. Do you have any of the following? Check ALL that apply

- | | |
|---|---|
| <input type="radio"/> 1. Chronic illness | <input type="radio"/> 7. Sensory Disability (i.e. hearing or vision loss) |
| <input type="radio"/> 2. Developmental Disability | <input type="radio"/> 8. Other (please specify) |
| <input type="radio"/> 3. Drug or Alcohol Dependence | <input type="radio"/> (8. Other) HIV |
| <input type="radio"/> 4. Learning Disability | <input type="radio"/> (8. Other) Diabetes or family history of Diabetes |
| <input type="radio"/> 5. Mental Illness | <input type="radio"/> 9. None _____ |
| <input type="radio"/> 6. Physical Disability | <input type="radio"/> 98. Do not know |
| | <input type="radio"/> 99. Prefer not to answer |

15. Are you currently pregnant?

If yes, how many weeks? _____ *(We do not accept clients more than 20 weeks pregnant)*

16. Please indicate the services you are interested in receiving:

- Medical Services (Nurse practitioner/Family Doctor)
- Chiropody/foot care
- Diabetes Care
- HIV Support, care and treatment for positive women
- Social Work

For Counselling Call Intake at 416-593-7655 Ext: 4867

17. How did you find out about us? Please specify

- Friend
- Family member
- School
- Community
- Health Centre
- Public Health Nurse
- Doctor
- Hospital
- Media
- Other: _____