INTAKE FORM:

WOMEN'S HEALTH
IN WOMEN'S HANDS
COMMUNITY HEALTH CENTRE
NCREASE • INNOVATE • IGNITE

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

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.

Date: ______________________________

Name

Last name: ______________________________ Preferred name: ____________________

First name: ______________________________ Middle names: ____________________

Birthdate: (day/month/year) ______________________________

1. **What is your gender?** Check **ONE** only

O 1. Female
O 2. Intersex
O 3. Male
O 4. Trans-Female to Male
O 5. Trans-Male to Female
O 6. Two-Spirit
O 7. Other (Please specify): ____________________
O 98. Do not know
O 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**

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

- O 1. Chronic illness
- O 2. Developmental Disability
- O 3. Drug or Alcohol Dependence
- O 4. Learning Disability
- O 5. Mental Illness
- O 6. Physical Disability
- O 7. Sensory Disability (i.e. hearing or vision loss)
- O 8. Other (please specify)
- O (8. Other) HIV
- O (8. Other) Diabetes or family history of Diabetes
- O 9. None
- O 98. Do not know
- O 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: 4912

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

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