INTAKE FORM:

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

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

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: _____

Date of Birth: _____

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. **Telephone**

Primary: _____

Alternate: _____

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

4. **Email Address:** _____

5. Health Insurance Coverage:

Interim Federal Health (IFH) program ○ OHIP ○ Other: _____

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

6. Do you reside in Canada? (*We only see residents of Ontario*) ○Yes ○ No

7. Do you have a Primary Care Provider (e.g. family doctor, nurse practitioner etc.) Yes ○ No ○

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

9. 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):** _____

10. 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 _____

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

_____

12. Do you need a cultural interpreter?

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

13. Are you currently pregnant?

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

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

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

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

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