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.



Date:			
Name			
Last name:	Preferred name:		
First name:	Middle names:		
Date of Birth:			
1. What is your gender? Check ONE only			
O 1. Female	O 6. Two-Spirit		
O 2. Intersex	O 7. Other (Please specify):		
O 3. Male	O 98. Do not know		
O 4. Trans-Female to Male	O 99. Prefer not to answer		
O 5. Trans-Male to Female			
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 OHII	Other:		
Health Insurance #: ——————	Version code	(if applicable):	
6. Do you reside in Canada? (We only see residents	of Ontario) OYes O No)	
7. Do you have a Primary Care Provider (e.g. family	doctor, nurse practitione	er etc.) Yes O	No O
8. If you currently have a primary care provider do y	you wish to transfer you	care? Yes O	No O
9. Are you receiving service at another Community	Health Centre?	Yes 🔾	No O
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 racia	I or ethnic group? Check	ONE only	
1. Asian-East (e.g., Chinese, Japanese, Korean)			
O 2. Asian-South (e.g., Indian, Pakistani, Sri Lank			
O 3. Asian-South East (e.g., Malaysian, Filipino,	•		
O 4. Black-African (e.g., Ghanaian, Kenyan, Somo	•		
O 5. Black-Caribbean (e.g., Barbadian, Jamaican	•		
O 6. Black-North American (e.g., Canadian, Ame			
O 7. First Nations	,		
O 8. Indian-Caribbean (e.g., Guyanese with origi	ns in India)		
O 9. Indigenous Aboriginal not included elsew	here		
O 10. Inuit			
O 11. Latin American (e.g., Argentinian, Chilean, Salvadoran)			
O 12. Metis			
O 13. Middle Eastern (e.g. Egyptian, Iranian, L	O 13. Middle Eastern (e.g. Egyptian, Iranian, Lebanese)		
O 14. White-European (English, Italian, Portug	O 14. White-European (English, Italian, Portuguese, Russian		
O 15. White-North American (e.g., Canadian,	American)		
O 16. Mixed heritage (e.g., Black-African & W	hite-North American)		
Please specify:			
O 17. Other(s) Please specify:			
O 98. Do not know			
O 99. Prefer not to answer			



Name	ne	IN WOMEN'S HANDS COMMUNITY HEALTH CENTRE INCREASE * INNOVATE * IGNITE
11. What	hat language would you feel most comfortable speaking in	with your health care provider?
12. Do yo	you need a cultural interpreter?	
Yes O	No O Language (including ASL, dialect):	
13. Are y	e you currently pregnant?	
If	If yes, how many weeks? ———— (We do n	ot accept clients more than 20 weeks pregnant
14. Pleas	ease indicate the services you are interested in receiving:	
0	O Medical Services (Nurse practitioner/Family Doctor)	
0	O Chiropody/foot care	
0	O Dietician/Diabetes Care	
0	O HIV Support, care and treatment for positive women	
0	O Social Work	
0	Mental Health Therapy	
15. Ho	How did you find out about us? Please specify	
0	O Friend	
0	O Family member	
0	O School	
0	O Community	
0	O Health Centre	
0	O Public Health Nurse	
0	O Doctor	
0	O Hospital	
0	O Media	
0	O Other:	