**363 Colborne Street Brantford ON. N3S 3N2**
**Telephone: (519) 754-0777**

**We are collecting social information from clients to find out what unique needs our clients have. We will also use this information to understand client experiences and outcomes.**

# Gender Affirming Clinic Intake Form

## General Information

Last Name: ______________________ First Name: ________________ Preferred Name: ____________________

Health Card #: ___________________Version Code (letters): _______________Expiry: ______________

Birth Date: __________ / __________ / ________ Note: clients must be at least 16 years old
(dd) (mm) (yy)

Address: ________________________________________________________________________________
(Apt. #) (No. And Street) (City) (Postal Code)

Preferred Contact #: _____________________Message allowed? Yes ☐ or No ☐
Back-up Contact #: ______________________Message allowed? Yes ☐ or No ☐

Your email Address: ________________________________
****at GRCHC we are starting to use email as a way to share information with our clients*****

Emergency Contact Name: _____________________________ Phone/Cell #: ________________________
Relationship: __________________________________ Message allowed? Yes ☐ or No ☐

Gender (check **one**): ☐ Male ☐ Female ☐ Intersex ☐ Trans female to male ☐ Trans male to female
☐ Two Spirit ☐ Gender fluid ☐ Other (please specify) ____________
☐ Do not know ☐ Prefer not to answer

***Only answer next question if this intake form is for yourself***
Sexual Orientation (check **one**): ☐ Heterosexual ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Queer ☐ Two Spirit
☐ Do not know ☐ Prefer not to answer

**I understand that my information will be stored in a secure electronic medical record, and will be kept confidential in accordance with Personal Health Information Protection Act (PHIPA).**

Client Signature: __________________________________________ Date: _____________________________

Please drop off, mail or fax your referral to our clinic. Our fax number is 519-754-0757