NORWEST CHC GENDER AFFIRMING CARE INTAKE FORM

Date Application Received: ____________________

PERSONAL INFORMATION

Full Name (as it appears on health card)			Pronouns
Preferred Name		Date of Birth (mm/dd/yyyy)	
Health Card Number	Version Code	Health Card Expiry	
Home Phone	Mobile Phone		
Email			
Mailing Address			

MEDICAL INFORMATION

Please tell us about your health care needs:

____
____
____
____

1. Do you currently have a primary care provider (doctor or nurse practitioner?)

☐ Yes
☐ No

2. Please note below any medications that you are currently taking (within the last year). If there are more than 5, please attached a list:

Medication	How much and how often?
1.	
2.	
3.	
4.	
5.	

NorWest Community Health Centres
Centres de santé communautaire NorWest

3. Please tell us about your gender affirming care journey

____
____
____
____
____
____

By signing below, you agree that there have truthful regarding your health history and social background and you also acknowledge you are currently not registered to another health care clinic/provider. Failure to properly disclose your health status may result in NorWest community Health Centres not being able to meet your health care needs.

First and Last Name: ____

Signature: ___________________________________ Date ______________________

NorWest Community Health Centres

Thunder Bay Site	**Armstrong Site**	**Longlac Site**	**Kakabeka Site**
525 Simpson Street	P.O. Box 104	99 Skinner Ave P.O. Box 910	4785 ON-11 Unit B
Thunder Bay, ON P7C 3J6	Armstrong, ON P0T 1A0	Longlac, ON P0T 2A0	Kakabeka Falls, ON P0T 1W0