TRANS HEALTH KLINIC
INTAKE FORM

Completed by (staff):_________

DATE: ______________________________

NAME (Legal/what's on your MB Health card): ____

NAME YOU GO BY: ____

PRONOUNS: ________________________________

BIRTHDATE: ________________________________

CURRENT ADDRESS: ____

Can we send mail to this address? Yes/No Special mailing instructions? ______________________

PREFERRED PHONE: _________________________ ALTERNATE PHONE:__________________________

Ok to leave message ______ Ok to leave message _______

Preferred time to receive calls: ___________________________

HOW DID YOU HEAR ABOUT THE TRANS KLINIC?:____

DO YOU CURRENTLY HAVE A FAMILY DOCTOR?:____

Anything else in specific our staff should be aware of prior to meeting?

____

Appointment booked: Date: ____
Time: ______________________________With____________________________

*Notes____
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