Klinic COMMUNITY HEALTH

Date received (fill by front desk): _____

TRANS HEALTH REGISTRATION FORM

Please complete all sections and return to Klinic front desk or by mail (address on p. 3)

Personal Information:

Chosen Name (First Name, Last Name): _____ Date of Birth: _____

Legal Name (Name on Health Card): _____
(Please include Middle Name)

Please let us know what name we should use when:

	Chosen Name	Legal Name	Use This Specific Name:
We Phone You	☐	☐	
Send Letters / Mail	☐	☐	
In the Waiting Room	☐	☐	

Pronouns: _____ Gender Identity: _____

Health Card Numbers:

Manitoba Health PHIN (9-digit): _____ MFRN (6-digit): _____

Other Province: _____ Health Card Number: _____

Contact Information:

Mailing Address: _____ Postal Code: _____

City: _____ Email (print clearly): _____

Physical Address (if different from above): _____ City: _____

Phone Number #1: _____ Please check type: ☐ Home ☐ Work ☐ Cell

Can we leave you a voicemail? ☐ Yes ☐ No

Phone Number #2: _____ Please check type: ☐ Home ☐ Work ☐ Cell

Can we leave you a voicemail? ☐ Yes ☐ No

Primary Care Information:

Name of Primary Care Provider: _____

Name of Primary Care Clinic: _____

Can we send your Primary Care Provider and Clinic guidelines for providing gender-affirming care in primary care practice?

☐ Yes ☐ No