Réseau ACCESS Network

Gender Affirming Service Client Intake Form

Client Information

Legal Name: _____

Name you use (if different from legal name): _____

Sex assign at birth: ☐ male ☐ female Gender: _____ Pronouns:_____

Date of birth (M/D/Y): _____ Phone number: _____

Email: _____

Health Card: _____

Family Doctor: _____

Do we have permission to send them documentation from your visit here? ☐ Yes ☐ No

Pharmacy: _____

Emergency contact: _____

Phone number: _____

Do we have permission to contact them? ☐ Yes ☐ No

Services Required

- ☐ HRT
- ☐ Gender affirming surgery referrals
- ☐ HIV, Hep C, and STBBI testing
- ☐ Hep C treatment
- ☐ Access to PrEP
- ☐ Supportive counselling
- ☐ Peer group support and education
- ☐ Referrals to other health care services
- ☐ Access to safer sex supplies
- ☐ Access to oral/injectable contraceptives

CLIENT ID: _____
Name of intake provider: _____
Date (M/D/Y): _____