INTAKE FORM

ALL PROGRAMS

Dr. Peter Centre

PERSONAL INFORMATION

Full Name _____

Date of Birth ____ /____ /____ Personal Health Number: _____

Pronouns ◯ He/Him ◯ She/Her ◯ They/Them ◯ Other: _____

Home Address _____

Phone Number _____ Email _____

Income Source _____ Identifies as Indigenous Yes ◯ No ◯

EMERGENCY CONTACT

Contact Name _____

Phone Number _____ Email _____

Relationship to Participant _____

CARE TEAM INFORMATION

Physician/NP _____

Case Manager _____ Organization _____

CLINICAL HISTORY

HIV Status _____ Most Recent Viral Load _____

Physical Health Issues _____

_____

_____

Allergies _____

PERSONAL HISTORY

Mental Health Diagnoses _____

Relevant Personal History _____

_____

_____

Mental Health Team _____

Interested in connecting with MH team? Yes ◯ No ◯

Other Organizations Accessed

JRC-SPH STOP Team ACT Native Health

AIDS Van AOT DCHC Ribbon Community

Other _____

INTAKE FORM

ALL PROGRAMS

Dr. Peter Centre

PROGRAMS

Art Therapy ○ Indigenous Wellness ○ Day Health (meals) ○

Music Therapy ○ Counselling ○ iOAT Program ○

Recreational Therapy ○ Medication Management ○ Other Supports: _____

Goals _____

_____

_____

_____

ENHANCED SUPPORTED HOUSING

ADLs/Functional Supports Laundry Cooking Transportation Mobility

Extra Support Other _____

Housing History _____

_____

Self Pay PWD Direct Withdraw

NOTES

_____

_____

_____

_____

_____

_____

_____ _____

Staff Member Participant

_____

Date