Guelph CHC
growing healthy together

Guelph Family Health Team

SYRIAN REFUGEE INTAKE FORM

This form will be used to register individuals for ongoing medical care (primary care) at the Guelph Community Health Centre or the Guelph Family Health Team. Please provide as much information as possible. Please complete one form per person and send forms together for people who should go through intake at one appointment (i.e. a family).

To be seen for an immediate health care concern at a Clinic for Newly Arrived Syrians - you do not need to fill out this form. Immediate Health Needs appointments can be booked at 519 821 6638, ext 2.

To register for ongoing Primary Care at either the Guelph CHC or the Guelph Family Health Team, please submit this form by fax to 519- 780-2080 or in person or by mail to:

Guelph CHC - downtown
176 Wyndham Street North
Guelph, N1H 8N9

Guelph CHC – Shelldale
20 Shelldale Crescent
Guelph, N1H 1C8

Number of people who should meet with health care provider for intake together: _____

Last Name:_____ First Name:_____ Preferred Name: _____

Gender: _____ DOB (Day/Month/Year):_____

Language(s) spoken: _____Preferred language of service: _____

Interpreter needed: Yes _____ No _____ Place of birth: _____

Date of arrival in Canada: _____

Approximate date of departure from Syria: _____

Most recent living situation: (refugee camp or urban) _____

Interim Federal Health Number or Ontario Health Insurance Number (circle one and give number):

_____

Highest level of education: _____

If person is school age, when did they last attend school: _____

Previous job: _____

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Brief description of health status: (example –list any regular medications, chronic disease, pregnancy, diet concerns, allergies)

_____

_____

_____

Current address: _____

Current phone number: _____

Part of town in which the person may live if the current address is short term: _____

_____

Any preference for a primary care location in Guelph: _____

Sponsorship group name: _____

Name and contact information for someone in the sponsorship group whom we may contact with information about client appointments:

_____

_____

Any other details that may help in planning for the care of this person's health care:

_____

_____

Form completed by- please circle-: Applicant / Family member / Sponsor / Other

Name: _____

Date: _____