OCCHC RAAM INTAKE FORM

GENERAL INFORMATION			
Last Name:		First Name:	
Sex Assigned at Birth: ☐ Female ☐ Male		Current Gender Identity:	
Pronouns (*optional*):		Health Card #: VC: Exp:	
Do you require an interpreter/translator? Yes ☐ No ☐		Name of Family Doctor or Nurse Practitioner & City:	
Address: Apt #	Address: Street # and Street Name:	City & Postal Code	
☐ No fixed address	Pharmacy & Location:		
Phone/Cell:	Consent to text? YES ☐ NO ☐	E-Mail Address:	
May we leave a message? YES ☐ NO ☐	Date of birth: (dd/mm/yyyy) _____/_____/_____		Age:

Part 2: DEMOGRAPHIC INFORMATION	
Race/Ethnicity:	Country of Birth *(if not Canada)*
Arrival Date in Canada:	Are you a: ☐ Canadian Citizen ☐ Landed Immigrant ☐ Refugee
What is your highest level of education completed? ☐ Elementary (K-8) ☐ Secondary (9-12/13) ☐ College ☐ University	
Sexual Orientation (optional):	
What are your sources of income (OW, ODSP, EI, Work)?	
What is Your Annual Household Income: ☐ Don't Know ☐ <$15,000 ☐ $15,000-$19,999 ☐ $20,000-$29,999 ☐ $30,000-$34,999 ☐ $35,000-$39,999 ☐ $40,000-$59,999 ☐ $60,000 plus	

How many people help bring in this income?	How many people are supported by this income?	How many dependents do you have?
Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Common-law ☐ Widow(er)		

PART 3: PLEASE REVIEW	
☐	**A urine sample is required for intake.** **Please see reception if you need to use the bathroom** (please check [√] to acknowledge)
☐	Please check [√] if you are interested in **Counselling supports ONLY.**
How did you hear about us? ☐Health care Provider ☐Emergency Dept. ☐Hospital (inpatient) ☐Mental Health ☐Other _____	

PART 4: ADMISSION INFORMATION

1. Substance Use Concerns: please [√] **ALL** that apply

	Alcohol (Beer, Wine, Spirits)		Opioids (fentanyl, morphine, dilaudid, heroine)
	Methamphetamines (crystal meth)		Benzodiazepines (Xanax, valium, lorazepam)
	Cannabis (marijuana, CBD)		Tobacco
	Cocaine		Over the counter codeine (Tylenol 1)
	Crack		Amphetamines (Adderall, Concerta)
	Hallucinogens (LSD)		Steroids
	Other psychoactive drugs		Barbiturates (phenobarbital)
	MDMA (ecstasy/molly)		Glue & Other inhalants

1. How ready are you to make a change to your substance use? (please circle a number form 1-10)

Not Ready									Ready
1	2	3	4	5	6	7	8	9	10

Please check [√] for each category:

2. Physical Health Status: ☐ Vision Impairment ☐Hearing Impairment ☐Mobility/Physical Impairment ☐I am Pregnant
3. Non-Medical IV Drug Use: ☐ Never Injected ☐ Injected Prior to 1 year Ago ☐ Injected in the Last 12 months
4. Have you ever shared equipment? ☐ Yes ☐ No
5. Number of overnight hospitalizations in the last 12 months: _____
6. Diagnosed with mental health problem by a qualified mental health professional? ☐ Yes ☐No
7. Hospitalized for a mental health problem? ☐ Yes ☐No
8. Please list any other health problems (i.e., Blood pressure problems, Cancer, Diabetes, Endocarditis, Heart problems, HIV/AIDS, Hepatitis, Kidney disease, Asthma, Migraine headaches, etc.):
   _____
9. Do you have any immediate safety concerns that you would like assistance with today or soon? ☐Yes ☐No
10. Did you ever lose consciousness (including as a result of overdose) or experience a period of being dazed or did you have a gap in memory from the injury? ☐ Yes ☐ No
11. Are you currently taking Naltrexone? ☐ Yes ☐ No
12. Are you currently taking Methadone/Suboxone/SUBLOCADE? ☐ Yes ☐No
13. Do you have a Naloxone Kit? ☐Yes ☐No
14. Other information that we should know?
    _____