



P.O. Box 832, 237 Second St.
Midland ON L4R 4P4
705 526-1305
Fax 705 526-9248
www.wendatprograms.com
info@wendatprograms.com

Brief Service Intake Form

Please fax a signed consent form to 705 526-9248 Consent Provided? yes No

Referral Date: _____ Referral Source: _____

Referral Source Phone #: _____ Email: _____

Client First Name: _____ Middle Name: _____

Last Name: _____ Alias: _____

Health Card #: _____ **DOB:** _____

Phone #: _____ Alternate phone # _____

May we leave a message? Yes No

CURRENT ADDRESS: _____

Language Spoken at Birth: _____ Preferred Language: _____

Cultural Identification Indigenous Metis Other _____

Gender: Female Male Non-Binary Other _____ prefer not to say

Marital Status: single married common law

Who do you live with: spouse adult children dependent children other _____

Education (highest level completed): _____

Mental Health Diagnosis: _____

GP: _____ Psychiatrist: _____

Other service providers you are connected with: _____



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Reason(s) for requesting support:

Income Source:_____ Total monthly income:_____

Special Considerations (mobility issues, literacy issues, medical issues etc.)

Risk Factors (substance abuse, legal issues, risk to self or others etc.):

Additional Comments:_____
