

### **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: \_\_\_\_\_



P.O. Box 832, 237 Second St.  
Midland ON L4R 4P4  
705 526-1305  
Fax 705 526-9248  
[www.wendatprograms.com](http://www.wendatprograms.com)  
[info@wendatprograms.com](mailto:info@wendatprograms.com)

Reason(s) for requesting support:

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Income Source: \_\_\_\_\_ Total monthly income: \_\_\_\_\_

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

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

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Additional Comments: \_\_\_\_\_

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