PHARMACY INTAKE FORM

This document assists pharmacy staff in providing you with the best care possible. Questions may or may not be applicable to you and all questions are voluntary. If you have any concerns, please see a member of the pharmacy team or call us at *902-417-2088*. Forms may be submitted in person or can be emailed to *info@boydspharmasave.ca*.

PATIENT INFORMATION

Legal name: ____________________ Name I Use: ____________________

How do you identify your gender: cis male cis female trans male trans female non-binary two-spirit I do not identify with a gender additional gender identities: ________ decline to state

Sex assigned at birth: male female decline to state Date of Birth: ____________________

Pronouns (select all applicable): he/him/his she/her/hers they/them/theirs other: ____________________

Address ____________________

City: ____________________ Province: ____________________ Postal Code: ____________________

Phone # (daytime): ____________________ Phone # (evening): ____________________

Health Card Number: ____________________

Insurance (include plan name, policy number, client ID, and carrier ID if applicable):

____

____

TRANSFER INFORMATION

Current Pharmacy: ____________________

Medication(s) to be transferred: ____________________ *or* entire file

CLINICAL INFORMATION

Family Practitioner: ____________________ Packaging Preference: regular vials snap cap vials compliance packaging

Medical Conditions: ____________________

____

Current Weight *(if under 18 years of age)*: ____________________ lb kg Current Height: ____________________

Allergies *(drug or food)* and reactions: ____________________ *or* No Known Allergies

PRESCRIPTION INFORMATION

Medication	Form	Strength	Directions

____________________ ____________________ ____________________

Printed name Signature Date