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*. Please be aware that any personal health information sent via email is an unsecure method of sending personal health information and we cannot guarantee that others outside of the pharmacy will not have access to your information.

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):

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TRANSFER INFORMATION

Current Pharmacy: ______________________

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

CLINICAL INFORMATION

Family Practitioner: ______________________ Packaging Preference: ☐ regular vials ☐ snap cap vials ☐ blister packaging

Medical Conditions: ______________________

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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