# 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: ______________________________ Preferred name: ______________________________

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 DOB: ______________________________

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 |
| --- | --- | --- | --- |
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______________________ Printed name

______________________ Signature

______________________ Date