



Intake Form for: Rey T. Singh MSW, RSW, CACII, RCS

Name of Client: _____ Date of Birth: _____

Referral made by: _____ Date of referral: _____

Referring agency or worker: _____ Phone: _____

Email address: _____

Insurance provider: _____ Policy Number: _____

Insurance Provider contact phone: _____

Status Card Number (if Applicable): _____ Band: _____

Name of Emergency contact: _____ Relation: _____

Address: _____

Legal Guardian (if applicable): _____ Phone: _____

Address: _____

Health Card Number: _____ Version Code: _____

Family Doctor: _____ Phone: _____ Fax: _____

Address: _____

Facility Doctor: _____ Phone: _____ Fax: _____

Other Professional Involvement (past or current): Probations: _____

Psychologist: _____ School/CAS Social Worker: _____

Pastoral: _____ Psychiatrist: _____

LHSC Social Work: _____ Drug & Alcohol Worker: _____

Name of client: _____ Date of Birth: _____

Current Mental Health Diagnoses:

Date of last diagnosis: _____ Diagnosing Physician: _____

Current Medications: _____

_____ Date Prescribed: _____

Naturopathic medications: _____

Past Non-prescribed Drug use: _____

Present Social Supports: _____

Currently resides with:

Relevant History: _____

Past Trauma History: _____

Reason for Referral: _____

