COMPLEXE CHIRURGICAL
GrS MONTRÉAL

Identification questionnaire

Please complete this questionnaire in order to facilitate coordination and organization of your care with other healthcare providers.

Identification

Legal name: Legal first name:

Name used: First name used:

Date of birth: Pronoun: He ☐ She ☐ They ☐

mm/dd/yyyy

Language of communication: French ☐ English ☐ Need a translator: Yes ☐ No ☐

Other ☐ (*please specify:* _____)

Health insurance number: Issuing province:

Full name registered on the card: Expiration date:

mm/yyyy

Contact information

Address:

Civic no **street** **App.**

City: Province: Postal code:

Country:

Daytime phone number: Evening phone number:

Cell phone number: Email address:

Contact in case of emergency

Person's name: Phone number:

Connection: E-mail:

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Contact details of your healthcare providers

Name of your attending physician:

Name and address of the clinic:

Phone number:

Name of your prescribers of hormone therapy:

Name and address of the clinic:

Phone number:

Name of another stakeholder, if applicable:

Name and address of the clinic:

Phone number:

Issuer of the first letter of recommendation: professional title:

Name: Phone number:

Issuer of the secondary recommendation letter if applicable: professional title:

Name: Phone number: