

CLINIC USE ONLY

Date Received: _____
 (dd/mm/yyyy)

Appointment Date: _____
 (dd/mm/yyyy)

Client Information

Last Name: _____ First Name: _____

Date of Birth (dd/mm/yyyy): _____ OHIP#: _____ (____)

I identify my gender as: Female Intersex Male Trans Female to Male
 Trans Male to Female Two-Spirit Other (Please Specify) _____

Address: _____

City: _____ Postal Code: _____

Home Number: _____ Cell Number: _____

Email address (optional): _____

I allow West Toronto DEP to contact me via email regarding updates and upcoming events? Yes No

Best time to contact you? am pm

Primary Language: English Other _____ Interpreter Needed? Yes No

Health Information

What type of diabetes are you living with? At risk Pre-diabetes Type 2

How do you manage your diabetes? Diet/Exercise Oral Medication Insulin

How long have you lived with diabetes? _____

Type of service requested: Individual counseling Group Education Session Physical Activity

What would you like to learn about? (Check all that apply)

Physical Activity Glucometer Reading Medication/Insulin
 Meal Planning High and Low Blood Sugars Stress Management
 Label Reading Smoking Cessation Complications
 Weight Management Other: _____