House of Friendship
STRONGER TOGETHER

RAPID ACCESS ADDICTION MEDICINE CLINIC

PARTICIPANT REGISTRATION FORM

PARTICIPANT INFORMATION

Name:		**Date of birth:**	
Pronouns:	*Gender Identity:*	*Ethnicity:*	*Preferred Language:*
Address:		**Phone Number:** *Consent for Voicemails?* ☐ Yes ☐ No *Consent for Text Messages?* ☐ Yes ☐ No	
City:			
Postal Code:		**Email:** *Consent for Emails?* ☐ Yes ☐ No	
County: ☐ *Waterloo* ☐ *Wellington* ☐ *Other*: _____		**Appointment Reminders** (*Please select one)* ☐ Phone Call ☐ Email ☐ None	
Emergency Contact: *Phone Number:* *Relationship:*		**Health Card Number:** *Version Code:* *Province:* *Expiry Date:*	
Do you identify as Indigenous, either First Nations people or Metis? ☐ Yes ☐ No		*Status Number:*	*First Nations Community:*

SUBSTANCE USE

Substance of Concern:	*Last time you used it:*
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Are you currently experiencing any withdrawal symptoms?

☐ Yes ☐ No

If yes, please explain:

REASON FOR VISIT

☐ Medical Provider/Medication ☐ Counselling/Referrals ☐ Peer Support ☐ Other

Additional Information:

Waterloo Region
Nurse Practitioner-Led Clinic