MANOR CLINIC

Registration Form

Demographical Information				
Name of Person *(FIRST, MIDDLE NAME(S) & LAST NAME)*			Today's Date	
Provincial Health Care Number: ☐ Out of Province		D.O.B. (*DD-MON-YYYY)*	Age	
Address:		Phone #:		
Primary Contact:		Phone #:		
E-mail address:				
Currently Resides:	☐ Alone ☐ With Family	☐ Supported Housing	☐ Hospital	☐ Other:
Family Physician:		Phone #:	FAX #:	
Pharmacy:		Phone #:	FAX #:	

Medications: Complete list of psychiatric & physical medications, & over-the-counter medications. Please bring list of medications with you if you cannot provide all the information here.	
1.	4.
2.	5.
3.	6.

Please complete if applicable:

Communication and Mobility:	**Please check all that apply**
Verbal: ☐ Yes ☐ No Preferred language:	Interpreter Required: ☐ Yes ☐ No
☐ Non-Verbal ☐ Gesture ☐ Sign ☐ Communication Aid	
Ability to Read: ☐ Yes ☐ No	Ability to Write: ☐ Yes ☐ No
Hearing:	Vision:
Mobility Issues: ☐ None ☐ Wheelchair ☐ Other:	

Guardianship and Decision Making	
Is there a Guardianship Order? ☐ Yes ☐ No If yes, provide a copy of order and primary contact info: Name: Phone Number:	Decision Making Ability Under The Adult Guardianship and Trusteeship Act (AGTA): ☐ Supported Decision Making ☐ Co-Decision Making ☐ Guardianship ☐ Specific Decision Making ☐ Trusteeship

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