Hôpitaux Shriners
pour enfants
Shriners Hospitals
for Children™

INTAKE FORM FOR SHRINERS HOSPITAL - CANADA

Child last name_____ First name_____

Date of Birth (yy/mm/dd)_____

Address (with Postal code/zip)_____

_____

Health care number (with expiry date) _____

Home Phone number: (_____) _____

Cell phone number: (_____) _____

Work Phone number: (_____) _____

E-Mail _____

Mom's maiden name_____

Dad's name _____

Name of insurance Company (if you have one)_____

In your own words, give us a short description of what medical care or services you are looking for when consulting with Shriners Hospital Montreal

If you have any medical information pertaining to the condition of your child, please include it and return all information to Louise Toupin (ltoupin@shrinenet.org) by e-mail, by fax or by regular mail using the coordinates below.

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