**CONFIDENTIAL**

# Gespeg Nation Member - COVID-19 VACCINATION INTAKE FORM

Please Print all information

## INTAKE INFORMATION

| DATE: | TIME: | INTAKE WORKER: |
|---|---|---|

## CLIENT INFORMATION

| Name: | Age: | D.O.B.: | Band Number: |
|---|---|---|---|
| Address: | | Email: | |
| Cell Phone: | | Home Phone: | |

Language for Correspondence: ☐ Kanien'kéha ☐ English ☐ Français

Preferred Correspondence: ☐ Home Phone, ☐ Cell Phone, ☐ Email, ☐ Text, ☐ Power of Attorney

| Emergency Contact: | Emergency Phone: |
|---|---|
| Power of Attorney: | Power of Attorney Phone: |

Current Employment Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ EI ☐ SA

| Place of Employment: | Type of Employment: |
|---|---|

## HEALTH INFORMATION

| | | |
|---|---|---|
| Do you have any chronic illness?? If YES, please list below | ☐ YES | ☐ NO |
| | | |
| Do you have any physical limitations? If YES, please list below | ☐ YES | ☐ NO |
| | | |
| Have you received Twinrix in the last 30 day?<br>If YES, include the Date: | ☐ YES | ☐ NO |
| Have you received any vaccination in the last 30 days?<br>If Yes,list below including the dtaes. | ☐ YES | ☐ NO |
| | | |
| Do you have any allergies? If YES, please list below | ☐ YES | ☐ NO |
| | | |

## CLIENT RISK FACTOR ASSESSMENT

| | | | |
|---|---|---|---|
| ☐ Autonomous | ☐ Semi-Autonomous | ☐ Non-Autonomous | ☐ Non-Mobile |
| ☐ Registered Band of Kanesatake<br>☐ Other Registered First Nations:<br>☐ Resident of J0N 1E0 | | ☐ Non-Resident, Community Employee<br>☐ Non-Resident<br>☐ Registered Non-Indigenous | |
| ☐ 16-17 | ☐ 18-59 | ☐ 60 and over | ☐ Riverside |

| | | |
|---|---|---|
| ☐ Anemic | ☐ Liver Disease (Cirrhosis) | ☐ Other: |
| ☐ Chemotherapy | ☐ Liver Disease (Hepatitis) | |
| ☐ Diabetes | ☐ Lung Disease | ☐ Other: |
| ☐ Heart Disease | ☐ Obesity | |
| ☐ HIV Positive | ☐ Radiotherapy | ☐ Other: |
| ☐ Hypertension | ☐ Taking Corticosteroids | |
| ☐ Immunocompromised | ☐ Taking Immunosuppressant Medication | ☐ Other: |
| ☐ Kidney Disease | ☐ Transplant Recipient | |

| OFFICE USE ONLY | **Manager:** |
|---|---|
| **Client Name:** | |

| APPOINTMENT INFORMATION; 1st Dose | | | |
|---|---|---|---|
| Appointment Date: | Appointment Confirmed by: | | |
| Clinic Location: | Brand of Vaccine: | | |
| Appointment Confirmation on: | Appointment Confirmed by: | | |
| Date of First call: | Appointment Scheduled? | ☐ YES | ☐ NO |
| Date of Second Call: | Appointment Scheduled? | ☐ YES | ☐ NO |

| APPOINTMENT INFORMATION; 2nd Dose | | | |
|---|---|---|---|
| Appointment Date: | Appointment Confirmed by: | | |
| Clinic Location: | Brand of Vaccine: | | |
| Appointment Confirmation on: | Appointment Confirmed by: | | |
| Date of First call: | Appointment Scheduled? | ☐ YES | ☐ NO |
| Date of Second Call: | Appointment Scheduled? | ☐ YES | ☐ NO |

| VACCINATION APPROVAL | **Manager:** | | | | | |
|---|---|---|---|---|---|---|
| Does the client qualify for vaccination? If YES, select priority group | | | | | ☐ YES | ☐ NO |
| ☐ Priority 1 | ☐ Priority 2 | ☐ Priority 3 | ☐ Priority 4 | ☐ Priority 5 | ☐ Priority 6 | ☐ Priority 7 |
| NOTES: | | | | | | |

| Signature: | | | Date: |
|---|---|---|---|
| Client Signature: | ☐ Digital | ☐ Informed Consent | Date: |
| Power of Attorney: | ☐ Digital | ☐ Informed Consent | Date: |

| HAS THE CLIENT PREVIOUSLY RECEIVED A COVID-19 VACCINE? IF YES, PLEASE SPECIFYBRAND AND DATE BELOW | ☐ YES | ☐ NO |
|---|---|---|
| Date of First Dose: | Brand of Vaccine: | |

| FOLLOW-UP | |
|---|---|
| NOTES: | |
| Signature: | Date: |

Signature of intake worker

Date