Hôpitaux Shriners
pour enfants®
Shriners Hospitals
for Children®

Canada

MRN#

Centre Shriners :

INTAKE FORM FOR SHRINERS HOSPITAL FOR CHILDREN® — CANADA

Child's last name: _____ First name: _____

Date of birth (YY/MM/DD): _____

Address: _____

City: _____ Province/State: _____

Postal code/Zip code: _____ Country: _____

Health insurance number: _____ Exp. Date: (MM/YY): _____

Home phone: ( ) _____

Cell phone: ( ) _____

Work phone: ( ) _____

E-Mail: _____

Mother's maiden name: _____ Mother's first name: _____

Father's last name: _____ Father's first name: _____

Name of insurance Company (if you have one): _____

In your own words, write a short description of what medical care or services you are looking for when consulting our Hospital.

If you have any medical information pertaining to the condition of your child, please include it and return all information be e-mail or regular mail, using the contact information below:

Please send this form and your medical request/referral through our web site:
www.shrinershospitalcanada.org/appointments in the New medical request/referral section.

1003, Decarie boulevard,
Montreal, QC Canada, H4A 0A9

Phone: (514) 282-6971
Toll free Canada:1-800-361-7256, ext. 6971