

Dear Primary Care Applicant,

**Starting April 1, 2025, the West Elgin Community Health Centre will prioritize new applicants from within West Elgin. The boundaries are:**

- **East of MacPherson Line**
- **West of Iona Road**
- **South of the Thames River**
- **North of Lake Erie**

**We will still accept applications from outside these boundaries, but we cannot predict when they will be accepted.**

Please complete the following forms:

1. **Summary of Services:** Check any services you want to learn more about or need a referral to.
2. **Primary Care Services Application**
3. **Medical History Questionnaire:** Complete the adult or child/youth form as appropriate.
4. **Chronic Pain History:** Fill this out if you take controlled substances like pain medication or sedatives.

Make sure all forms are fully completed to avoid delays. Applicants are not excluded due to complexity. The information you provide helps us understand your needs and balance our client load.

After we receive your forms, you will be added to our waitlist. You will be contacted for an intake appointment, when space becomes available

**Intake appointments are longer than usual. It is very important to attend or cancel at least 48 hours in advance. If you miss the appointment without notice, your name may be moved down or removed from the waitlist.**

At the intake visit, you will not be prescribed medications or treatments. We will review your medical history and discuss your needs. Do not leave your current provider until after this visit. If your provider is closing, get enough prescriptions to last several months.

Submit your completed forms by:

- Dropping them off
- Mailing to: West Elgin Community Health Centre, 153 Main Street, West Lorne, ON. N0L 2P0
- Faxing to: 519-768-2548

Avoid emailing forms as it's not secure. For questions, contact reception or call 519-768-1715 ext. 2241.

Sincerely,

Rick van der Heide  
Primary Health Services Director

## APPLICATION FOR PRIMARY CARE SERVICES

Name: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
First Middle Last Name (All names as on Health Card)

Street: \_\_\_\_\_  
Box # Apt. # or R.R # House # or 911 # Street Name

\_\_\_\_\_  
City / Town Province Postal Code

Health Card OHIP #: \_\_\_\_\_ Version #: \_\_\_\_\_ Expiry: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
DD MM YYYY

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ E-mail: \_\_\_\_\_  
Day Month Year

**Please list telephone numbers where you can be reached:**

Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

What number do you want us to use first? ☐ Home ☐ Cell ☐ Work

At what number(s) can we leave a voice message – check all that apply. ☐ Home ☐ Cell ☐ Work

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Current/Previous Care Providers:**

Do you currently have a Family Doctor or Nurse Practitioner (provider)? ☐ Yes ☐ No

Care Providers Name: \_\_\_\_\_ City: \_\_\_\_\_

Approximately how many appointments do you typically require from doctor/nurse practitioner each year? This helps us to divide clients with more frequent needs among providers: \_\_\_\_\_ / year

If you do not currently have a provider, who was your last primary care provider?

Care Providers Name: \_\_\_\_\_ Date last see: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Day Month Year

\_\_\_\_\_  
Signature Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Day Month Year

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For Centre Use only

1 2 3 4 Provider \_\_\_\_\_ Time \_\_\_\_\_

# ADULT MEDICAL HISTORY FORM

Your answers on this form will help your health care provider get an accurate history of your medical concerns and conditions. **Please fill in all pages.** If you cannot remember specific details, please provide your best guess. Thank you!

**IMMUNIZATIONS:** Check off any vaccinations you have had. Add year, if known.

Tetanus (Td) \_\_\_\_\_ With Pertussis(Tdap) \_\_\_\_\_

Influenza (flu shot) \_\_\_\_\_

Pneumovax (pneumonia) \_\_\_\_\_

Varicella (Chicken Pox) shot or illness \_\_\_\_\_

Hepatitis A \_\_\_\_\_

Hepatitis B \_\_\_\_\_

MMR

Zostavax (shingles)

## Meningitis

HPV

**MEDICATIONS:** Please list all prescriptions and non-prescription medications, vitamins, birth control pills, herbs, inhalers, etc. Use the back of this form if you need more room or attach list from pharmacy.

☐ I DO NOT TAKE ANY MEDICATIONS

## Medication

Dose (e.g. mg/pill)

**How many times per day?**

[illegible]

Please list below all allergies or intolerances to medications, food, environment. ☐ **No Known Allergies**

**Allergen**

**Type of Reaction**


**HEALTH MAINTENANCE SCREENING TESTS:**

Lipid (cholesterol)	Date_____	Abnormal?	No	Yes
Sigmoidoscopy or Colonoscopy (circle one)	Date_____	Polyp?	No	Yes
Fecal Occult blood Test	Date_____	Abnormal?	No	Yes

***Women only:***

Mammogram	Date_____	Abnormal?	No	Yes
Pap Smear	Date_____	Abnormal?	No	Yes
Bone Density Test	Date_____	Abnormal?	No	Yes

**PERSONAL MEDICAL HISTORY:**

Do you have now (current) or have you had (past) any of the following conditions? ☐ **NONE**

Condition	Current	Past	Comments
Alcohol/Drug abuse			
Allergy (Hay Fever)			
Anemia			
Anxiety			
Arthritis			
Asthma			
Bladder/Kidney Problems			
Blood Clot (leg)			
Breast Lump (Benign)			
Cancer Breast			
Cancer Colon			
Cancer Other Type			
Cataracts			
Chicken Pox/Shingles			
Coronary Artery Disease			
Depression			

Condition	Current	Past	Comments
Diabetes			
Diverticulosis			
Emphysema/COPD			
Fractures (broken bones) Please list			
Gallbladder Disease			
Gastroesophageal Reflux (Heartburn/GERD)			
Glaucoma			
Gout			
Gynecological Conditions			
Heart Attack			
Hepatitis			
High Blood Pressure			
High Cholesterol			
Hip Fracture			
Irritable Bowel Syndrome			
Kidney Disease / Failure			
Kidney Stones			
Liver Disease			
Migraine Headaches			
Osteoporosis			
Pregnancy			
Prostate			
Seizures / Epilepsy			
Skin Conditions			
Sleep Apnea			
Stomach Ulcer			
Stroke			
Thyroid			
Other (list)			

## SURGICAL HISTORY

Please check off any procedure or surgeries. List any abnormal finding or complications ☐ NONE

Surgical Procedure	Yes	Year	Comments
Abdominal Surgery			
Appendectomy (appendix removal)			
Back Surgery			
Biopsy (location)			
Breast Surgery			Circle: Right Left Both
Colonoscopy			
Coronary Bypass			
Coronary Stent			
Stomach Endoscopy			
Cataract			
Gallbladder Removal			Circle: Laparoscopic
Heart Surgery (other than bypass)			
Hip Surgery			Circle: Right Left Both
Hysterectomy			Circle: Laparoscopic Vaginal Abdominal
Knee Surgery			Circle: Right Left Both
LEEP (Cervix Surgery)			
Neck Surgery			
Ovary Ligation ("Tubal")			
Ovary Removal			Circle: Right Left Both
Vasectomy			
Sigmoidoscopy			
Sinus Surgery			
Other (list)			

## WOMEN'S HEALTH HISTORY:

Total number of pregnancies: \_\_\_\_\_ Number of births: \_\_\_\_\_

Age at beginning of periods (menstruation): \_\_\_\_\_ Age at end of periods (menopause): \_\_\_\_\_

Date (month/day if known) of last menstrual period if you are still menstruating: \_\_\_\_\_

Are you pregnant? ☐ No ☐ Yes Who is monitoring your pregnancy \_\_\_\_\_

**FAMILY HISTORY** – Indicate which relative has had the following diseases.

[illegible]

**OTHER HEALTH ISSUES:**

<b>Tobacco Use:</b> Have you ever smoked cigarettes: <input type="checkbox"/> No <input type="checkbox"/> Yes Still smoking? <input type="checkbox"/> No <input type="checkbox"/> Yes If you smoked and quit, list quit date: _____ How many years did/have you smoked: _____ If quit, # packs/day did you smoke: _____ Current Smoker: Packs/day _____	<b>Exercise:</b> Do you exercise regularly? <input type="checkbox"/> No <input type="checkbox"/> Yes What kind of exercise? _____ _____ _____ How long do you exercise (minutes) _____ How Often? _____
<b>Alcohol Use:</b> Do you drink alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes # of drinks/week _____ Beer    Wine    Liquor	<b>Diet:</b> How would you rate your nutrition/diet? Good                      Fair                      Poor Would you like advice on your diet? <input type="checkbox"/> No <input type="checkbox"/> Yes
<b>Drug Use:</b> Do you use marijuana/recreational drugs: <input type="checkbox"/> No <input type="checkbox"/> Yes Have you ever used needles to inject drugs: <input type="checkbox"/> No <input type="checkbox"/> Yes Current use: _____	

**OTHER SUPPORTS:**

Are you currently seeing any other specialist/service/counselor? State name/why seeing/when last seen

Who: \_\_\_\_\_ When Last seen: \_\_\_\_\_

WHY \_\_\_\_\_

\_\_\_\_\_

Are you currently seeing any other specialist/service/counselor? State name/why seeing/when last seen

Who: \_\_\_\_\_ When Last seen: \_\_\_\_\_

WHY \_\_\_\_\_

\_\_\_\_\_

Are you currently seeing any other specialist/service/counselor? State name/why seeing/when last seen

Who: \_\_\_\_\_ When Last seen: \_\_\_\_\_

WHY \_\_\_\_\_

\_\_\_\_\_



## SOCIAL HISTORY, GOALS AND SUPPORTS:

This information helps us to better understand who you are, your strengths and your support systems. It will also help to identify your beliefs, values and cultural preferences so that we can incorporate them into your care where possible.

Highest level of education completed: \_\_\_\_\_

Circle one:      Working      Retired      Unemployed      Leave of absence      Disabled      Other

Occupation (or prior occupation): \_\_\_\_\_

Employer: \_\_\_\_\_

Marital status (circle one):      Single      Partner      Married      Divorced      Widowed

Spouse/partner's name: \_\_\_\_\_

Number of children: \_\_\_\_\_ Ages if under 18 years: \_\_\_\_\_ Number of grandchildren: \_\_\_\_\_

Do you live alone? \_\_\_\_\_ If not alone, who lives with you? \_\_\_\_\_

Do you have access to transportation for appointments/programs/personal needs? \_\_\_\_\_

State any specific transportation requests/needs: \_\_\_\_\_

Do you have access to sufficient funds/benefits to cover costs of medications/treatments? ☐ NO ☐ YES

If no, please explain: \_\_\_\_\_

Are you receiving ODSP/Ontario Works or other form of financial support to assist you? ☐ NO ☐ YES

If YES, please list: \_\_\_\_\_

Please identify any cultural/religious preferences/needs that you would like us to know about so we can incorporate them into your care:

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Please list any specific goals you would like to work on with your care team:

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If you have legally appointed a Power of Attorney for Personal Care (PAPC) to make health care decisions on your behalf if you became unable to do so, please list their contact information below. If you do not have a PAPC, the law lists who the person would be in order of position (e.g. spouse, parent, child, sibling etc.).

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**If you have a written Advanced Care Plan, please provide us with a copy for your file.**

We know that having conversations about your care wishes can often be difficult. To help to ensure that decisions made on your behalf are in keeping with your beliefs and values, we suggest that everyone, no matter your age or health status, talk about your wishes with your family/substitute decisions makers.

Please list below, anything else you feel it would be helpful for us to know.

**Please review the next few pages regarding other services we offer. Services are free and you do not have to see a doctor or nurse practitioner to access these additional services.**

**We ask that you either check that you do not wish to be contacted or select the services you are interested in learning more about/getting an appointment with.**

While you await your intake appointment for Primary Care, please know we have many other services which may be of interest/help to you. A summary of our programs and services is attached (or go to our website: [wehc.on.ca](http://wehc.on.ca))

**Check off the services below** that you wish more information on/would like an appointment with. We will contact you.

☐ I AM NOT INTERESTED IN BEING CONTACTED ABOUT ANY ADDITIONAL SERVICES

OR

I AM INTERESTED IN BEING CONTACTED TO LEARN MORE ABOUT (CHECK ALL THAT APPLY)

- ☐ ASSISTED LIVING
- ☐ DIABETES EDUCATION PROGRAM
- ☐ DIETITIAN SERVICES
- ☐ FIRST FIVE WEST ELGIN
- ☐ HEALTH PROMOTION
- ☐ LET'S CONNECT
- ☐ MENTAL HEALTH SERVICES
- ☐ PHYSIOTHERAPY
- ☐ SENIORS AND ADULTS WITH DISABILITIES
- ☐ SYSTEMS NAVIGATION
- ☐ TRANSPORTATION SERVICES

**SEE BRIEF SUMMARY OF PROGRAMS ON NEXT FEW PAGES OR VISIT OUR WEBSITE**

## SUMMARY OF PROGRAMS AND SERVICES OFFERED AT WECHC

**ASSISTED LIVING:** Our qualified Support Workers provide services in the municipalities of Dutton/Dunwich and West Elgin. They can assist with personal care, light housekeeping, laundry services, medication reminders and checks, security checks and social support. There is no cost for services to eligible clients.

**DIABETES EDUCATION PROGRAM (DEP):** Our DEP teams offer individual and group education, diabetes management and support with flexible hours at multiple locations in Elgin County. All adults (18+) living with Type 1 and 2 diabetes or prediabetes, and those at risk for diabetes are invited to access these free services. You may be referred to us by your primary care provider or you can self-refer by calling us. The registered nurses/dietitians work closely with your primary care provider to help you self-manage your diabetes to minimize or delay the onset of diabetes complications.

**DIETITIAN SERVICES:** We offer free dietitian services to support clients making changes to their diet to prevent chronic diseases, manage conditions, or for individual reasons. Eating healthy doesn't mean restricting yourself or your family. When it comes to food, we promote a philosophy of balance to meet your preferences and goals.

**FIRST FIVE WEST ELGIN:** This is one of our newest programs it is meant to address infants and children from newborn to 5 years of age who do not already have a Primary Care provider (MD/NP) but who are actively seeking Primary Care. This program is staffed by a Nurse Practitioner and a Registered Practical Nurse who are highly skilled in addressing the needs of this age group. This program offers well baby/child assessments, vaccinations, referral requests and acute illness assessments and treatment. We have locations within WECHC and at Southwest Public Health in St Thomas.

**HEALTH PROMOTION:** At West Elgin CHC we believe that health is more than just the absence of illness. Wellness includes the ability to participate in maintaining your health and to make informed choices. Health includes a sense of physical, mental, emotional, spiritual, and social well-being. Health Promotion is based on the social determinants of health including food, housing, education, income, peace and justice, physical environment, healthy child development and social supports. By addressing these factors, our health promoters and staff coordinate and facilitate a range of programs including exercise, food, community education and support groups. These programs are aimed to improve the lives and well-being of all participants, including those with chronic diseases or disabilities. Helping you stay healthy is our priority!

**LET'S CONNECT:** The Let's Connect team offers a variety of programs and services for children, families, and expectant and new parents. Some of our programs include fun family events, prenatal and infant programming, breastfeeding support, nutrition, and cooking programs. All Let's Connect programs are free. The CENTRE offers youth engagement opportunities through the Youth Advisory Committee. The Let's Connect team continues to explore youth programming for the community.

**MENTAL HEALTH SERVICES:** Our counsellors provide free, non-judgmental counselling services for people of all ages to help manage short or long-term challenges in a supportive environment. We help you to identify goals and find solutions to address many different challenges including depression, stress, abuse, parenting, grief and loss support, relationship, and family problems and more. In addition to counselling, the team can help clients access services related to housing, finances, crisis management and psychiatry/psychology. To access mental health services, please complete a self-referral form. These can be found at reception or on our website. You will receive a call once the self-referral form is received. Please note, there is a waiting list for mental health services.

**NEEDLE EXCHANGE PROGRAM:** In partnership with Elgin St. Thomas Public Health (ESTPH), we offer Naloxone kits (nasal spray) and training for those with friends or family at risk of an opioid overdose. We also offer a needle exchange program where you can access supplies at no cost to you. We believe in providing a safe place for people to access clean supplies and dispose of used drug equipment. We do not enable or encourage the use of illicit drugs. This program has been developed to reduce the burden and transmission of illnesses like HIV, Hepatitis B and Hepatitis C while improving safety in our community. No need to book an appointment, walk in and reception will be happy to provide you with supplies.

**PHYSIOTHERAPY:** The Centre works with West Lorne Talbot Trail Physiotherapy to offer financial support for physiotherapy to individuals. If you do not have physiotherapy benefits or your benefits have run out, call Talbot Trail Physiotherapy (519-768-3998) to see if you meet the criteria for this physiotherapy program. You do not need a medical referral for this service, we accept self-referrals.

**SENIORS AND ADULTS WITH DISABILITIES:** Community Support Services are an important link in our community allowing seniors and adults with disabilities to remain independent, and able to remain in their own home or community for a longer period. You **do not** have to see a doctor or nurse practitioner at the Centre to access these programs and services. Some of our programs and services include friendly visiting/telephone reassurance checks, meals on wheels, congregate dining, caregiver support, virtual programs, fitness groups, regularly scheduled programs, and activities and much more.

**SYSTEMS NAVIGATION:** Systems Navigators assist people to understand and find their way through health care, community, and social service systems. There are times when people facing life's challenges do not know what kinds of help are available to them in the community and health care field. Systems Navigators support individuals and families to discover and access appropriate programs and services.

**TRANSPORTATION SERVICES:** A support service that provides transportation to medical appointments, shopping and to various social activities and programs. Screened volunteers use their own vehicles to provide transportation and a friendly visit along the way. The fare is based on per/km and invoiced monthly. Accessible transportation is also available with our Community Health Shuttle for a fee for service. Our "Gift-a-Ride" program is funded by The United Way of Elgin/St. Thomas and available to individuals' requiring transportation to essential appointments and have insufficient funds.