West Elgin Community Health Centre

Every One Matters.

Referral Form for Counselling Services at WECHC

Please note: There is currently a waitlist for counseling services. All referrals will be handled in a confidential manner and will become part of your medical file. If you do not have a medical provider at WECHC a new record will be created with the information you provide. Please speak to our Privacy Officer for more information.

Client information:

Legal Name (as it appears on your health card):		
Name you go by:		Age:
Date of Birth:	Gender:	
Is the client aware of, and agreeable to, the referral?	☐ yes	☐ unsure ☐ no

Referral source information:

Today's date:		
Referral source:	☐ primary provider ☐ self	☐ agency ☐ parent
Referral source's contact information:		

Residence and family information:

Client resides with (name):		
Relationship to referred client:		
Address:		
City:	Province:	Postal Code:
Home phone: Can a message be left at this number?	Other phone: Can a message be left at this number?	

Health information:

Health card number :	expiration date: version code:
Medical Provider:	Other :

Other agency involvement:

Name of agency	Past involvement (list dates)	Current involvement (list dates)

Reason for requesting counselling:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

History of client:

Is there a history of any of the following?	No	Past	Current (within the last 6 months)	Details
Diagnosis of mental illness				
Medication for mental illness				
Hospitalization for mental illness				
Thoughts of suicide				
Suicide attempt				
Self-harming behavior				
Legal involvement				
Violent behavior				
Physical abuse				

Is there a history of any of the following?	No	Past	Current (Within the last 6 months)	Details
Sexual abuse				
Emotional abuse				
Witness of family violence				
Other trauma				
Elder abuse (emotional, physical, financial, neglect)				
Head injury with loss of consciousness				
Intellectual challenges/learning disabilities				
Diagnosis of dementia or memory loss				

Guardian information (regarding a child or youth):

Parent name:	Parent name:	
Name of individual(s) who have legal custody: *If parents are separated please provide the name(s) of all people who are formally recognized as having custody*		
Address of Custodial Guardian		
City:	Province:	Postal code:
Home phone:	Other phone:	

Is the referral for an immediate family member (spouse, child, sibling or parent) of a WECHC employee? Yes or No

Thank you for taking the time to complete this form. Only fully completed forms will be processed.