West Elgin Community Health Centre

First Five West Elgin

Referral Form – First Five West Program

Eligibility (both must apply)

☐ Child is 0-5 years old; AND
☐ Child has no Family Doctor or Nurse Practitioner

Parent/Guardian Information		
Parent/Guardian Name:		Phone #:
Address:		Email:
City:		Postal Code:
Languages Spoken:		
Preferred Language:		Do you require translation services? ☐ Yes ☐ No
Child Information		
Name:		Date of Birth:
Does your child have OHIP? ☐ Yes ☐ No	If yes, Health Card # and Version Code:	
Address (if different from parent/guardian):		
Previous Care Provider:		Pharmacy:
Reason for Referral (Select all that apply)		
☐ Newborn care ☐ Well Baby/Well Child Visit ☐ Nutrition Support ☐ Other: ____________________________		☐ Developmental Screening ☐ Newborn care

Consent for Electronic Communication:

☐ Parent/guardian consents for the West Elgin Community Health Centre - First Five West Program to send a Program Intake form to personal email using a secure online patient messaging platform (called "OCEAN").

Referral Source:

☐ Self-referral How did you hear about the First Five West Program?

☐ Agency/Community Referral (please include contact details below)

Name:	Agency:
Address:	Phone #:
Email:	Fax #:

Please fax this completed form to 519-765-1279.

Disclaimer: We will aim to contact the person referred within 1-2 business days and will attempt contact three times.

If you have any general questions about the First Five West Program, please call 519-773-3715 ext. 131 and ask to speak with Jodi. Thank you.