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 519-768-2548.

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 519-768-1715 ext. 2301 and ask to speak with Katherine. Thank you.