

## Referral Form for Counselling Services at WECHC

**Please note:** *There is currently a waitlist for counselling services.*

**Referrals are only accepted if the client is a resident of the Dutton Dunwich and West Elgin Municipality area and/or already assigned to our Primary Care Team; that is, they have a physician or nurse practitioner they see at the West Elgin Community Health Centre.**

*Referrals that do not meet the criteria **will not be contacted.***

*If your application for counselling is accepted, you will receive a letter confirming your position on the wait list.*

**It is very important to understand that this is not a crisis service. If you are in crisis, please contact REACH OUT at 1-866-933-2023 or text 9-8-8 for immediate support.**

Do you reside within the West Elgin Municipality and the area of Dutton Dunwich?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Unsure
Do you currently have a WECHC medical provider (doctor or nurse practitioner)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Unsure
Do you have an immediate family member (i.e. spouse, child, sibling, or parent) who is employed at WECHC?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Unsure

**Client information:**

Legal Name (as it appears on your health card):	
Name you go by:	
Date of Birth:	Gender:
Phone Number:	Alternate Phone #:
Can a message be left at this number?	Can a message be left at this number?
Email:	
Address:	
Health card number :	expiration date:
	version code:
Medical Provider:	

**Referral source information:**

Today's date:		
Referral source:	<input type="checkbox"/> primary provider	<input type="checkbox"/> agency
	<input type="checkbox"/> self	<input type="checkbox"/> parent
Referral source's contact information:		
Is the client aware of, and agreeable to, the referral?	<input type="checkbox"/> yes	<input type="checkbox"/> unsure <input type="checkbox"/> no

**Reason for requesting counselling:**

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**IF UNDER 18 YEARS OF AGE**

I consent to WECHC contacting my parent(s)/guardian(s) for the purpose of scheduling appointments.

**Guardian information (regarding a child or youth):**

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

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