West Elgin Community Health Centre

Every One Matters.

Referral Form for Counselling Services at WECHC

Please note: Psychotherapy is a process where individuals work with a trained professional to explore their thoughts, feelings, and behaviors. To be effective, clients need to be motivated to actively participate and make positive changes in their lives

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** and the application for mental health services will be destroyed in accordance with strict confidentiality protocols.*

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 dial 9-8-8 for immediate support.***

All applications will be handled in a confidential manner and, if accepted, will become part of your medical file. If you do not have a medical provider at the Centre, a new record will be created with the information you provide. Please speak to our Privacy Officer for more information.

Thank you for your understanding.

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

Client information:

Legal Name (as it appears on your health card):		
Name you go by:		Age:
Date of Birth:	Gender:	

Referral source information:

Today's date:		
Referral source:	☐ primary provider ☐ self	☐ agency ☐ parent
Referral source's contact information:		
Is the client aware of, and agreeable to, the referral?	☐ yes	☐ unsure ☐ no

IF UNDER 18 YEARS OF AGE

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

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:

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History of client:

Is there a history of any of the following?	No	Past	Current (within the last 3 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 3 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:	

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