Referral Form

Please fax/email completed forms to *Jodi*: 519-765-1279 or jrossiter@eefht.ca

Eligibility (please check all that apply)
☐ Currently Pregnant/Expecting ☐ In need of postpartum care ☐ Child is 0-6 years old ☐ Child or patient has no Family Doctor or Nurse Practitioner

Reason for Referral	
Prenatal or Postnatal Care:	**Infant and/or Child Care:**
☐ Prenatal care ☐ 6-week postpartum check ☐ Nutritional Support ☐ Pre or postnatal mood disorder screening	☐ Newborn care ☐ Well baby or well child assessment ☐ Immunizations ☐ Nutritional Support ☐ Developmental Screening

Parent/Guardian Information
Parent/Guardian Name:
Address:
Phone:
Email (if available):
Do you require translation services: ☐ **Yes** ☐ **No**
If yes, in which preferred language:

Child Information (ONLY required if referral is for child)
Name:
Date of Birth:
Health Card # and Version Code (if available):

Referral Source (if available):

For additional information, please contact **Jodi**, at the East Elgin Family Health Team at **(519) 773-3715 ext. 131**. We will be in contact with you after **1-2 business days**.