



Primary Care Access Clinics • Self-Referral Form

Client information

Name _____ Date of birth (mm/dd/yyyy) _____

Address _____ City _____ Postal Code _____

Phone _____ Email _____

Health Card Number _____ My pronouns are: She/Her He/Him They/Them Other

Family Doctor or Nurse Practitioner: _____ Phone: _____

Check this if you do not have a family doctor or nurse practitioner

Please check the educational programs you would like to attend:

Available Programs:

Blood Pressure Clinic Psychoeducational groups Smoking Cessation Other _____

Please check which individual appointments you would like to attend:

I need to see a doctor or a nurse practitioner for:

Preventative Health Care Cancer Screening Support of non-urgent or chronic health conditions

I have the following health care concerns:

Sexual Health Pregnancy Support Well Baby

Help to Quit Smoking Counselling Child Appointment Acute Illness

Nutrition counselling Mental health counselling,

Please indicate if there is additional information you would like the healthcare provider to know or if you are interested in other health services:

Interested in other health services: _____

Phone Appointment In-person Appointment **Bring a List of all Medications to your appointment**

Email completed form to Access@NorfolkFHT.ca or Drop off at 25 Curtis Avenue N, Paris

Please allow three business days for a response.

Prima Care Community Family Health Team Phone: 519-442-9834 • pccfht.ca

For emergencies, call 911 or go to the nearest emergency department.

FOR OFFICE USE ONLY

Referral received: Self-referral Provider Community / PH Other

Eligibility verified: Insured Uninsured Within geography

Interpreter required: No Yes (language): _____

Urgency: Same-day 72 hrs Routine

Appointment booked: Date/Time: _____ Provider: NP RN

Notes:

Admin initials: [Initials]
