TELEMEDICINE PATIENT REFERRAL

Fax to: 519-985-2612
Attn: April Reed / Teresa McGregor

REFERRING PHYSICIAN INFORMATION

Physician Name: _____

Phone Number: _____ Ext: _____ Alternate Number: _____

Fax Number: _____

CONSULTANT INFORMATION

Primary Service Specialty: _____

Consultant Name: _____

Phone Number: _____ Ext: _____ Alternate Number: _____

Fax Number: _____

☐ Urgent ☐ Non-urgent Requested Time Frame: _____

PATIENT INFORMATION

Patient's Name: _____

Date of Birth: _____ Age: _____ ☐ Female ☐ Male ☐ Transgender

OHIP Number: _____ VC: _____

Home phone Number: _____ Alternate Phone Number: _____

Mailing Address: _____

City: _____ Province: _____ Postal Code: _____

Alternate Contact Name: _____ Phone Number: _____

ADDITIONAL INFORMATION

Reason for Referral: _____

Appointment Type: ☐ Interview Style: ☐ Nursing Support Required for Assessments (Be Specific):

_____

_____

Special Requirements: _____

Sent By: _____ Date: _____