



## Telemedicine Referral Form

### **Appointment Request**

Specialist Request \_\_\_\_\_ Specialty Name (if known) \_\_\_\_\_

New Patient Consult  Follow Up  WSIB # \_\_\_\_\_

### **Patient Information**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Male  Female  OHIP \_\_\_\_\_ VER \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Prov \_\_\_\_\_ Postal Code \_\_\_\_\_

Phone# (H) \_\_\_\_\_ Phone# (W/Cell) \_\_\_\_\_

### **Reason for Referral (Please attach relevant reports including current list of medication)**

### **Referring Physician/HCP Information**

Referring Physician/HCP \_\_\_\_\_ Family Physician/HCP \_\_\_\_\_

Phone# \_\_\_\_\_ Fax# \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Prov \_\_\_\_\_

Billing Number \_\_\_\_\_

**Signature of Referring HCP** \_\_\_\_\_ **Date** \_\_\_\_\_