NOTE: Incomplete and / or unsigned requistions will be returned

PLEASE PRINT CLEARLY
OR AFFIX LABEL WITH COMPLETE INFORMATION

Patient Name: ______________________________
Last First

Date of Birth: ______________________ Sex: F M
Day Month Year

Health Card # ______________ Version Code: __________

Address: ______________________ Postal Code: ______

Telephone # (Best Daytime): ______________________

Alternate #: ______________________

Preferred Language: ______________________

CLINICAL TELEMEDICINE CONSULT/ REFERRAL

Please Fax to: (905) 472-7088

Clinical Telemedicine Coordinator: (905) 472-7373 ext 6202

Referrals are subject to review

Clinical consult/referral form must precede supporting documentation when faxing

Date	Contact Preference ☐ Patient ☐ Parent ☐ Substitute Decision Maker ☐ Alternate
Alternate Contact	Telephone

Referring Physician/HCP Information

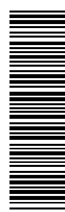
Referring Physician/HCP		Referring Physician is same as: ☐ Consultant ☐ Family Physician
Billing #	Telephone	Fax
Address	City	Postal Code
Family Physician	Telephone	Fax
Address	City	Postal Code

Appointment Information

Primary Service (Specialty)	Consultant Name
Telephone	Fax

Priority of Appointment ☐ Elective ☐ Urgent/Emergent	Event Date	Event Time	Duration	Appointment Type ☐ New Patient ☐ Follow-up

Patient Preferred Site	Consultant Preferred Site
☐ Markham ☐ Uxbridge ☐ LTCH (specify): ______________ ☐ Other OTN site# ____________ OTN system: ____________ TMC: ______________	OTN site# ____________ OTN system: ____________ TMC: ______________



Reason for Referral and Appointment Details
(If consultant is identified, please attach relevant reports including current list of medications.)

Special Requirements for the Patient and Appointment (Patient mobility, oxygen requirements, etc.)

☐ Nursing support required for consult ☐ Other:

☐ AMD Camera

☐ Digital stethoscope

Signature of Referring Physician/HCP	Date

CLITCR (4/16) (9/15)