NOTE: Incomplete and / or unsigned requistions will be returned

PLEASE PRINT CLEARLY
OR AFFIX LABEL WITH COMPLETE INFORMATION

MARKHAM STOUFFVILLE HOSPITAL CORPORATION

CLINICAL TELEMEDICINE CONSULT/ REFERRAL

Please Fax to: (905) 472-7088

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

Patient Name: _____ (Last) _____ (First)

Date of Birth: _____ (Day) _____ (Month) _____ (Year) Sex: F M

Health Card # _____ Version Code: _____

Address: _____ Postal Code: _____

Telephone # (Best Daytime): _____

Alternate #: _____

Preferred Language: _____

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