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 FROM LONG TERM CARE HOME

Please Fax to: (905) 472-7078

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) ☐ Fracture Clinic	Consultant Name			
Telephone	Fax			
Priority of Appointment ☐ Elective ☐ Urgent/Emergent	Event Date	Event Time	Duration	Appointment Type ☐ New Patient ☐ Follow-up
Patient Preferred Site ☐ Markham ☐ Uxbridge ☐ LTCH (specify): _____ ☐ Other OTN site# _____ OTN system: _____ TMC: _____		Consultant Preferred Site 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.)

Signature of Referring Physician/HCP	Date