KEEWAYTINOOK OKIMAKANAK eHEALTH TELEMEDICINE

ONTARIO TELEMEDICINE NETWORK RÉSEAU TÉLÉMÉDECINE ONTARIO OTN RTO

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KO TELEMEDICINE REFERRAL FORM Fax to 1-807-735-1089

Date of Request:

KO Telemedicine use	Patient studio:	Appointment Date: DD / MM/ YY	Appointment Time:

Specialty Requested: ***Specialist name:***

Referring Physician: **Tel:** **FAX:**

Referring Physician OHIP Billing #: **City:** **Postal Code:**

Patient Name: **Date of Birth:** **Sex:**

Health Card No: **Version:** **Preferred Language:**

Address: **Postal Code:** **Band No.:**

Tel (H): **Tel (W):**

Please complete if patient is less than 18 years of age:

Mother's Name: FIRST / LAST **Tel (H):** **Tel (W):**

Father's Name: **Tel (H):** **Tel (W):**

Guardian's Name: **Tel (H):** **Tel (W):**

Purpose of Consult: ❑ **Initial Consult** ❑ **Follow-up** ❑ **WSIB** **Claim No.** _____

If not seen by Telemedicine, would this referral require the patient to travel?

❑ **Yes** ❑**Yes, possibly** *(please explain)*: ❑ **No** *(please explain)*:

Reason for referral (please attach relevant reports/documents):

Physician Signature: **whoever initiated consult can sign here**