north simcoe
family health team

Telemedicine Program Referral Form

OTN Request

SPECIALTY REQUEST

SPECIALIST'S NAME (If unknown, OTN will provide assistance)

☐ URGENT

TYPE OF APPOINTMENT: ○ NEW PATIENT CONSULT ○ FOLLOW-UP VISIT

REFERRING PHYSICIAN INFORMATION

REFERRING PHYSICIAN'S NAME (First/Last) | PHONE | FAX

REFERRING PHYSICIAN OHIP BILLING NUMBER | FAMILY PHYSICIAN'S NAME (First/Last if different from above)

ADDRESS | CITY | PROVINCE | POSTAL CODE

E-MAIL ADDRESS (if email communication wanted)

PATIENT INFORMATION

NAME (First/Last) | DATE OF BIRTH (DD/MM/YY) | ○ MALE ○ FEMALE

HEALTH CARD NUMBER | VERSION CODE | EXPIRY DATE (DD/MM/YY)

ADDRESS | CITY | PROVINCE | POSTAL CODE

CURRENT PHONE NUMBER (Home) | ALTERNATE PHONE NUMBER (Work/Cell) | PREFERRED LANGUAGE

SUPPLEMENTAL INFORMATION (not always required)

PARENT/GUARDIAN/SUBSTITUTE DECISION MAKER | PHONE (Home) | PHONE (Work/Cell)

REASON FOR REFERRAL (please attach relevant reports, medical history and medication list.

SIGNATURE OF REFERRING PHYSICIAN

Please fax completed referrals to 705-526-1205

To discuss referral, contact Elisa Matheson, RN, Telemedicine Coordinator at 705-526-7804 x 211