KO TELEMEDICINE REFERRAL FORM

Fax to 1-807-735-1089

Date of Request:

Chrt# **CST**

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):

Site __________ System _______

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