Canadian Mental Health Association
Haliburton, Kawartha, Pine Ridge

CMHA HKPR Peterborough Community Telemedicine Clinic

GENERAL REFERRAL FORM

Please fax to CMHA HKPR

Fax: **705-748-5649** Attn: Jill Staples Phone: 705-748-6687 ext. 1034

REFERRING PHYSICIAN INFORMATION				
Referring Physician Name **Prov. Billing #:**	**Work Phone Ext.**	**Alternate Phone**	**Fax Number**	**Referring Physician is same as** ☐ Consultant ☐ Family Physician
Street Address	**City**	**Province**	**Postal Code**	

APPOINTMENT INFORMATION			
Primary Service (Specialty)	**Consultant** Name	**Priority of Appointment** ☐ Elective ☐ Urgent/Emergent	**Diagnosis if known or suspected:**
FOR OFFICE USE ONLY **Event Date:** _____ **Event Time:** _____			**Patient Preferred Site** PETERBOROUGH COMMUNITY TELEMEDICINE CLINIC **5355**
Reason for Referral (including current list of medications):			
Special Requirements for the Patient and appointment (Patient mobility, oxygen requirements, etc.)			

PATIENT INFORMATION					
Name	**Date of Birth (DDMMYYYY)**	**Age**	**Sex** ☐ M ☐ F ☐ OTHER	**Prov. Health Card#:**	**Version Code**
Home Phone	**Alternate Phone Ext.**			**Effective date:**	**Expiry date:**
Street Address	**City**			**Province**	**Postal Code**
Contact Preference	**Alternate Contact Name**			**Phone Ext.**	

REFERRING AGENCY NAME:	Worker :	Email:	TELEPHONE:	FAX:	REFERRAL DATE:

Signature of Referring Physician / Medical Professional **DATE:**

Note: The information contained in this form is confidential. It contains personal health information that is subject to the provisions of the *Personal Health Information Protection Act*, 2004. This form and its contents should not be distributed, copied or disclosed to any unauthorized persons.