**CMHA VIRTUAL CARE PSYCHIATRIC CLINIC**

**REFERRAL FORM**

Please fax to CMHA HKPR **VIRTUAL CARE PSYCHIATRIC CLINIC**

Fax: **705-748-5649** Attn: Jill Staples/Wendy Braund Phone: 705-748-6687 ext. 1034/1035

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

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| **APPOINTMENT INFORMATION** | | | | |
| **Primary Service (Specialty)**  **PSYCHIATRY** | **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  **5355-02** | |
| **Reason for Referral (including current list of medications):**  **Special Requirements for the Patient and appointment (Patient mobility, oxygen requirements, etc.)** | | | | |

and appointment Details (If consultant is identified, please attach relevant reports including current list of

medications.)

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| **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.