Canadian Mental Health Association
Haliburton, Kawartha, Pine Ridge

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

REFERRING PHYSICIAN INFORMATION

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

APPOINTMENT INFORMATION

Primary Service (Specialty)	Consultant Name	Priority of Appointment	Diagnosis if known or suspected:
PSYCHIATRY		☐ Elective ☐ Urgent/Emergent	

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.)

PATIENT INFORMATION

Name	Date of Birth (DDMMYYYY)	Age	Sex	Prov. Health Card#:	Version Code
			☐ M ☐ F ☒ OTHER		

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.