Canadian Mental Health Association
Haliburton, Kawartha, Pine Ridge

CMHAHKPR VIRTUAL CARE PSYCHIATRIC CLINIC REFERRAL FORM

Please fax to CMHAHKPR **VIRTUAL CARE PSYCHIATRIC CLINIC** Program
Attn: OTN Nurses Jill Staples & Shaye Martorino & Admin Wendy Braund
PHONE: 705-748-6687 ext. 1034/1038/1035 **FAX:** 705-748-5649

Please fill out the whole form or it will be returned to your office.

REFERRING PHYSICIAN INFORMATION IS REQUIRED

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 IS REQUIRED

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

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.)
If the referral form is not completely filled out, in will be returned to the referring physician.

PATIENT INFORMATION IS REQUIRED

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:

Require 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.