Canadian Mental Health Association
Haliburton, Kawartha, Pine Ridge

CMHA HKPR Peterborough Community Telemedicine Clinic

REFERRAL FORM

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

Fax: **705-748-5649** Attn: OTN Nurse's Jessica Swift/Kara Sicker Phone: 705-748-6687 ext. 1034

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**	

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 **5355-02**
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** ☐**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:**