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 Nurse's Jessica Swift / Kara Sicker and Admin Wendy Braund
PHONE: 705-748-6687 ext. 1034/1035 **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** ☐**Consultant** ☐**Family Physician**
Prov. Billing #:				
Street Address	**City**		**Province**	**Postal Code**

APPOINTMENT INFORMATION IS REQUIRED			
Primary Service (Specialty)	**Consultant** **PSYCHIATRY**	**Priority of Appointment** ☐ Elective	**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.) **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** ☐**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:**

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