Canadian Mental Health Association
Haliburton, Kawartha, Pine Ridge

Ontario Telemedicine Network
VIRTUAL CARE PSYCHIATRIC CLINIC
REFERRAL FORM

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

Now accepting EMAIL requests.

EMAIL: **OTN.clinic@cmhahkpr.ca** FAX: **705-748-5649**
Phone: 705-748-6687 ext. 1034

REFERRING PRACTITIONER INFORMATION

Name of Referring Practitioner (MD/NP):	Provincial Billing #:
Work phone number:	Ext:
Fax number:	
Mailing address: City: Province: Postal Code: Unit #:	
Signature of Referring MD/NP (Required):	**Date (DD/MM/YYYY):**

CLIENT INFORMATION

First Name: Last Name:	Gender:	Pronoun(s):
Date of Birth (DD/MM/YYYY):	Health Card #:	Version Code: Expiry: (DD/MM/YYYY)
Home address: City: Province: Postal Code: Unit #:		
Preferred Method of Contact: ☐Phone ☐E-mail ☐Text Message Telephone: Consent to voicemail and/or text messages: ☐**Yes** ☐**No** E-mail: Consent to communication via E-mail: ☐**Yes** ☐**No**		
Is there need for an interpreter? ☐ **Yes** ☐ **No** If yes, please specify which language:	Are there any accessibility concerns? ☐**Yes** ☐**No** If yes, please specify:	

REASON FOR REFERRAL

Diagnosis (if known or suspected):

Please indicate the primary reason for referral:

Medications list attached: ☐ **Yes** ☐ **No**