



Referral for Telemedicine Consultation

Primary Care Provider Information

Last Name	First Name	Please attach physician label here (Including OHIP billing #)
Phone Number	Fax Number	

Patient Information

Last Name	First Name	Please attach patient label here (Including OHIP #)
Patient Best Contact #	SDM Name and Contact #	

Consultation Request

Preferred Specialist Name	<input type="checkbox"/> Urgent – please call 416 586 4800 ext. 2844 <input type="checkbox"/> Non – urgent <input type="checkbox"/> Initial <input type="checkbox"/> Follow-up <input type="checkbox"/> Interpreter services required - if so please specify: <input type="text"/> If other, Please specify: <input type="text"/>
Specialty Requested	
<input type="checkbox"/> Please recommend a specialist in the discipline indicated	

Copy of Continuous Patient Profile attached (medical summary, medication list, recent labs, investigations, old consult notes)

Reason for Consultation Request

Signature: _____

Date: _____

Please fax referral form and all supporting documentation to (416) 586- 3168