ONTARIO TELEMEDICINE NETWORK
RÉSEAU TÉLÉMÉDECINE ONTARIO
OTN RTO

Fax to **1.888.879.2807** for
the OTN Scheduling Services

OTN USE ONLY

SITE NAME/SYSTEM NO.

APPOINTMENT DATE (DD/MM/YY)

APPOINTMENT TIME

PATIENT REFERRAL FORM

APPOINTMENT INFORMATION

DATE OF REQUEST (DD/MM/YY) | SPECIALIST'S NAME (If unknown, OTN will provide assistance) | SPECIALTY REQUEST

TYPE OF APPOINTMENT: ❍ NEW PATIENT CONSULT ❍ FOLLOW-UP VISIT WSIB#:

REFERRING PHYSICIAN INFORMATION

REFERRING PHYSICIAN'S NAME (First/Last) | PHONE | FAX

REFERRING PHYSICIAN OHIP BILLING NUMBER | FAMILY PHYSICIAN'S NAME (First/Last if different from above)

ADDRESS | CITY | PROVINCE | POSTAL CODE

E-MAIL ADDRESS

PATIENT INFORMATION

NAME (First/Last) | DATE OF BIRTH (DD/MM/YY) ❍ MALE ❍ FEMALE

MOTHER'S MAIDEN NAME | FATHER'S FIRST NAME

HEALTH CARD NUMBER | VERSION CODE | EXPIRY DATE (DD/MM/YY)

ADDRESS | CITY | PROVINCE | POSTAL CODE

CURRENT PHONE NUMBER (Home) | ALTERNATE PHONE NUMBER (Work/Cell) | PREFERRED LANGUAGE

SUPPLEMENTAL INFORMATION (not always required)

PARENT/GUARDIAN/SUBSTITUTE DECISION MAKER | PHONE (Home) | PHONE (Work/Cell)

IF KNOWN: NAME OF TELEHEALTH SITE | TIME OF CONSULT | ESTIMATED LENGTH OF CONSULT

REASON FOR REFERRAL (please attach relevant reports including current list of medications)

In accordance with the *Personal Health Information Protection Act, 2004 (Ontario),* I agree to be bound by 'Terms and Conditions for Referring Clinicians' as currently posted on the OTN website www.otn.ca or available on request by calling 1.866.454.OTN1.

SIGNATURE OF REFERRING PHYSICIAN