Belleville and Quinte West Community Health Centre

Attach Patient

Information Label

Telemedicine Clinical Referral Form

Referring Physician Information

Fax to: 613-962-5669

Referring Physician/Nurse Practitioner First Name Last Name		Family Physician if different from Referring First Name Last Name	
Work Phone Ext.	Alternate Phone	Fax Number	Prov. Billing Number
Street Address		City	Province / Postal Code

Appointment Information

Primary Service (Specialty)	Consultant (preferred) First Name Last Name	Priority of Appointment 1 Week _____ 1 Month_____	Appointment Type Initial_____ Follow Up_____
Reason for Referral and Appointment Details (please attach additional information on a separate sheet if necessary)			
Medications:			
Documents Attached:			

Signature of Referring Physician/ NP/Medical Professional Date