



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

Note: The information contained in this form is confidential. It contains personal health information that is subject to the provisions of the Personal Health Information Protection Act, 2004. This form and its contents should not be distributed, copied or disclosed to any unauthorized persons. If you have accessed this form in error, please contact the referring physician immediately.

**If problems faxing please contact Belleville & Quinte West CHC @ 613-962-0000 x 258**

**Dec 2023**

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69 Catherine St Trenton K8V 5K9 613-965-0698