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<br>First Name Last Name | | Family Physician if different from Referring<br>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)<br>First Name Last Name | Priority of Appointment<br>1 Week _____<br>1 Month_____ | Appointment Type<br>Initial_____<br>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.