154 MISSISSAUGA ST E, L3V 1V7 ORILLIA ONTARIO / TEL: 1-888-49A-VAIL / FAX: 1-705-986-0152

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

This document contains personal health information and must be protected in accordance with Ontario's *Personal Health Information Protection Act, 2004.*