TSM #:

**TELEMEDICINE CLINICAL SCHEDULING FORM** 

Fax to OTN Scheduling Services 1.888.879.2807

(Internal use only)

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Please note: Clinical scheduling form must precede supporting documentation when faxing

REFERRING PHYSICIAN INFORMATION									
Referring Physician First Name	I	Last Name	Family Physician First Name		Referring Physician is same as Consultant Family Physician				
Work Phone	Ext.	Alternate Phone	Fax Number	Prov. Billing Number					
Street Address			City	Province	Postal Code				

APPOINTMENT INFORMATION									
Primary Service (Specialty)	Consultant First Name Last Na	ame	Work Phone Ext.	Fax Number					
Priority of Appointment	Event Date (DDMMYYYY)	Event Time	Duration	Appointment Type					
Patient Preferred Site		Consultant Preferred Site							
Reason for Referral and Appointment Details (If consultant is identified, please attach relevant reports including current list of medications.)									

PATIENT INFORMATION								
First Name	Last Name	Date of Birth (DDMMYYYY)	Age	Sex				
Home Phone	Alternate Phone Ext.	Preferred Language	Prov. Health Card No.	Version Code				
Street Address		City	Province	Postal Code				
Contact Preference	Alternate Contact First Name	Last Name	Phone	Ext.				
Special Requirements for the Patient and Appointment (Patient mobility, oxygen requirements, etc.)								

## Signature of Referring Physician / Medical Professional

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 or OTN Scheduling at 1.866.454.OTN (6861) immediately. v 2.1



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