TELEMEDICINE CLINICAL SCHEDULING FORM

Fax to OTN Scheduling Services 1.888.879.2807

TSM #: _____ (Internal use only)

Thread #: _____ (Internal use only)

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

REFERRING PHYSICIAN INFORMATION

Referring Physician First Name / Last Name	Family Physician First Name / Last 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
	HEARST	ON	P0L 1N0

APPOINTMENT INFORMATION

Primary Service (Specialty)	Consultant First Name / Last Name	Work Phone / Ext.	Fax Number

Priority of Appointment	Event Date (DDMMYYYY)	Event Time	Duration	Appointment Type
Elective				New Patient

Patient Preferred Site	Consultant Preferred Site
e	

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
			Female

Home Phone	Alternate Phone / Ext.	Preferred Language	Prov. Health Card No.	Version Code

Street Address	City	Province	Postal Code
		ON	

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 **DATE**

 v 2.1