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
		ON	

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

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
		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**

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