A Part of Kingston Community Health Centres

Patient Name _____

Date of Birth (DD/MM/YY) _____

Health Number _____

Address _____

Preferred phone number _____

Telemedicine Services

Clinical Referral Form

Phone: 613-542-2949 ext. 1170 **Fax: 613-542-7657**

Referring Physician Information

Referring Physician/Nurse Practitioner First Name Last Name	Family Physician if different from Referring First Name Last Name
Work Phone – Ext. Fax Number	Provincial Billing Number
Address	City Province Postal Code

Appointment Information

Primary Service (Specialty) *if dermatology see below	Consultant/Specialist (Preferred)	Appointment Type Initial _____ Follow Up _____	Priority of Appointment Urgent _____ Less Urgent _____
Reason for Referral and Appointment Details *For dermatology consults, please include all relevant information i.e. symptoms, exacerbating factors, recent travel or medication changes, current medications, location, etc. **Special requirements (example oxygen, mobility, language)			

Signature of Referring Physician/Medical Professional Date