HURON PERTH ONTARIO TELEMEDICINE NETWORK
PRIMARY CARE NURSE PRACTITIONER PROGRAM

Primary care for individuals 16 and older with mental health and/or addiction concerns, and the complex frail elderly who are without a primary care provider (special circumstances at discretion).

Date:_____

Patient Name:_____

DOB: _____ Health Card # _____

Patient Confirmed Phone #:_____

Able to leave voice message: Y__ N

Address: _____
(STREET ADDRESS, SUITE, POSTAL CODE)

Alterative contact information: _____
_____

Medical Concerns: _____
_____
_____
_____

Past Medical History: _____
_____
_____
_____

Community Supports and Specialists involved: _____
_____
_____

Please attach a List of Patient Medication from a Pharmacy or a Medication Reconciliation

Pharmacy:_____

Allergies:_____
_____

Safety Concerns for providers:_____
_____

Current/Past Criminal Charges: _____
_____

Referred by:_____ Agency:_____
Contact #_____ Ext._____ Fax #:_____

Referrals can be faxed to 519-527-8420. **For more information please contact 519-527-8421 ext.4818.**

It will be the responsibility of the referring party to contact the client with the initial appointment time.

Please attach medical history, current medication list, lab results, and any information which may be relevant to this referral. – *thank you*