NORTH Network
Bringing health care closer to home.

KO TELEMEDICINE REFERRAL FORM

FAX to 1-807-735-1089

KO Telemedicine
Formerly KO Telehealth

Date of Request:

KO Telemedicine use	Patient studio:	Appointment Date: DD / MM/ YY	Appointment Time:

Specialty Requested: | **Specialist name** *(if known)*:

Referring Physician: | **Tel:** | **FAX:**

Address: | **City:** | **Postal Code:**

Patient Name: | **Date of Birth:** | **Sex:**

Health Card No: | **Version:** | **Preferred Language:**

Address: | **Postal Code:** | **Band No.:**

Tel (H): | **Tel (W):**

Please complete if patient is less than 18 years of age:

Mother's Name: (FIRST / LAST) | **Tel (H):** | **Tel (W):**

Father's Name: | **Tel (H):** | **Tel (W):**

Guardian's Name: | **Tel (H):** | **Tel (W):**

Purpose of Consult: ☐ **Initial Consult** ☐ **Follow-up** ☐ **WSIB** **Claim No.**

If not seen by Telemedicine, would this referral require the patient to travel?

☐ **Yes** ☐ **Yes, possibly** *(please explain)*: ☐ **No** *(please explain)*:

Reason for referral (please attach relevant reports/documents):

Physician Signature: