NORTHERN HEALTH REGION CONSULTATION REFERRAL FORM

Patient Name: _____(last),_____(first)

DOB (DD/MM/YYYY): _____ PHIN:_____

Address (street, town, province, postal code): _____

Telephone #: _____ (home);_____(cell)

Can patient safely travel to Thompson by car: yes / no (circle appropriate)

Date of Injury:_____

Clinical History and Present Symptoms:

_____

_____

Past Medical History:

_____

_____

Current Medications:

_____

_____

Previous Investigations and Results (CT, MRI, neuropsychological testing etc.):

_____

_____

Previous Consultations/Treatments:

_____

_____

Requesting physician:

_____(print);_____(signature)

Billing #: _____

Address (street, town, province):_____

Telephone:_____ Fax:_____

All Pan Am Clinic CONNECT Program referrals will be screened for eligibility to undergo clinical consultation and follow-up through MBTelehealth in Thompson, Manitoba. ***Please fax fully completed referral forms to (204) 927-2768***