



**The Pan Am Clinic CONCUSSION in the North EConsult, and
Telemedicine (CONNECT) Program**

VIDEOCONFERENCING CONSULTATION REFERRAL FORM

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

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

Address (street, town, prov/territory, postal code): _____

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

Patient age: _____ Sex: Male Female Gender: (Please specify) _____

Date of Injury: _____

Clinical History and Present Symptoms:

Past Medical History:

Current Medications:

Previous Investigations and Results (x-ray, CT, blood work etc.):

Previous Consultations/Treatments:

Requesting

physician: _____ (print); _____ (signature)

Billing #: _____

Address (street, town, prov/territory): _____

Telephone: _____ Fax: _____

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