



LAST NAME	(FIRST)
MRN	VISIT NUMBER
DATE OF BIRTH DD-MM-YYYY	SEX
ADDRESS	
IMPRINT OR ENTER DETAILS BY HAND	

Tele-Mental Health Services Follow-up Form

Date of request: _____ Agency client #: _____ MRN: _____
DD - MM - YYYY

Coordinating agency: AFS Dilico HANDS SOAHAC Strides Weechi-it-te-win Woodview

CLIENT INFORMATION

Patient's name: _____ Preferred name: _____
LAST, FIRST

Sex at birth: M F Gender: _____ DOB: _____
DD - MM - YYYY

Health card #: _____ Version: _____ Exp: _____
DD - MM - YYYY

REFERRING AGENCY INFORMATION

Referring agency / Hospital / Physician: _____

Address: _____ City: _____

Telephone: _____ Ext: _____ Fax (1 per agency / location): _____

Case manager: _____ Email: _____

CONSULTATION INFORMATION

Follow-up consultation Second opinion Extended consult

Date of last consultation: _____ Name of consultant: _____
DD - MM - YYYY

Reason for request (be specific):

Date(s) case manager, client / family is *unavailable* for consultation: _____

Requested timeframe: _____

CENTRAL INTAKE USE ONLY
<input type="checkbox"/> Consent valid (signed within the last year)