# Bluewater Health Telemedicine Clinical Scheduling Form
## Fax to: 519-464-4547

| Referring Physician Information | | |
|---|---|---|
| **Referring Physician** (First and Last Name) | | |
| **Family Physician** (First and Last Name) | | |
| Phone Number | Fax Number | Billing Number |
| Street Address | City, Province | Postal Code |
| **Appointment Information** | | |
| **Consultant** (First and Last Name) | Event Date (DD/MM/YYYY)<br>Event Time (HH/MM) | Priority |
| Phone Number | Fax Number | ☐ Initial Consult<br>☐ Follow-up |
| Patient Preferred Site<br>☐ Bluewater Health Sarnia Site<br>☐ CEEH of Bluewater Health | Consultant Preferred Site | Duration of Appointment |
| Reason for Referral and Appointment Details | | |
| **Patient Information** | | |
| **Patient** (First and Last Name) | Date of Birth (DD/MM/YYYY) | Sex |
| Phone Number(s) | Health Card Number | Version Code |
| Street Address | City, Province | Postal Code |
| *Please attach relevant reports including current Medication List* | | |

Signature of Referring Medical Professional

Date (DD/MM/YYYY)