



Religious Hospitallers  
of Saint Joseph  
of the Hotel Dieu of Kingston  
**HOTEL DIEU HOSPITAL**

## Telemedicine Clinical Referral

Telephone: 613-544-3400 Ext. 3104  
Fax: 613-545-2200  
Internet: [www.hoteldieu.com](http://www.hoteldieu.com)

Patient Name: \_\_\_\_\_  
CR #: \_\_\_\_\_  
Health Card #: \_\_\_\_\_  
Date of Birth (yyyy/mm/dd): \_\_\_\_\_  
Gender: \_\_\_\_\_  
Address: \_\_\_\_\_  
Preferred phone #: \_\_\_\_\_

Referring practitioner: \_\_\_\_\_  
*First name* *Last name*

Telephone & extension: \_\_\_\_\_ Fax: \_\_\_\_\_

Referring practitioner is same as:  Consultant  Family physician

Family physician:  
(if different from referring practitioner) \_\_\_\_\_  
*First name* *Last name*

Provincial billing number: \_\_\_\_\_

Address: \_\_\_\_\_  
*Street* *Apartment*  
\_\_\_\_\_  
*City* *Province* *Postal code*

### Appointment Information

Primary service (specialty): \_\_\_\_\_

Consultant/specialist: \_\_\_\_\_  
*First name* *Last name*

Appointment priority:  Urgent (1-2 days)  Semi-urgent (3-14 days)  Elective \_\_\_\_\_ (days/weeks/months)

Appointment type:  Initial  Follow-up

Patient preferred site: \_\_\_\_\_

Reason for referral and appointment details: (indicate any special requirements for patient (e.g., mobility, oxygen, etc.))

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Referring practitioner:

\_\_\_\_\_  
Printed Name Designation Signature Date (yyyy/mm/dd) Time (hhmm)

### INTERNAL USE ONLY (to be completed by Consultant's Secretary)

Tentative appointment date: \_\_\_\_\_ Time: \_\_\_\_\_ Duration in minutes: \_\_\_\_\_  
*yyyy/mm/dd* *hhmm* *mm*

Consultant's secretary: \_\_\_\_\_  
*First name* *Last name*

**SCAN TO REFERRAL TELEMEDICINE**  
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