**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***