Tele-Mental Health Services
provided by

SickKids® vanier CHEO

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: _____ (DD - MM - YYYY) Agency client #: _____ MRN: _____

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

CLIENT INFORMATION

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

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: _____ (DD - MM - YYYY) Name of consultant: _____

Reason for request (be specific):

_____

_____

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

_____

Requested timeframe: _____

CENTRAL INTAKE USE ONLY

☐ Consent valid (signed within the last year)