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Child and Adolescent Psychiatry

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Physician's Referral Form - videoconference - via OTN

Patient's Name:

Gender:

DOB:

HCN:

VC:

Phone #:

Parent's Name:

email:

Referring Physician:

OHIP #:

Fax #:

Medical Problems

Current Medications

Allergies:

Reason for Referral - What's Your Question?

Have the parents/caregivers been given the web address in order to complete their intake questionnaires?

www.doctortempleman.com/parents

YES

OTN site co-ordinator's Name: _____

email: _____