

Tele-Mental Health Services,
provided by



LAST NAME	(FIRST)
MRN	VISIT NUMBER
DATE OF BIRTH YYYY-MM-DD	SEX
ADDRESS	
IMPRINT OR ENTER DETAILS BY HAND	

Follow-up Form

Agency Client #: _____ MRN: _____ Date of Request: _____
YYYY - MM - DD

Coordinating Agency: AFS Dilico EMYS HANDS SOAHAC Weechi-it-te-win Woodview

Referring Agency: _____

Location: _____ Telephone #: _____

Fax # Report is to go to (1# per agency / location): _____

Case Manager: _____

Second Opinion Follow-up Consultation

Client Name: _____ DOB: _____
YYYY - MM - DD

Health Card Number: _____ Version Code: _____ Expiry Date: _____
YYYY - MM - DD

Date of Last Consultation: _____
YYYY - MM - DD

Name of Consultant: _____

Reason for Request (please be specific): _____

Dates Clinician is NOT available: _____

Requested Timeframe: _____

<p>CENTRAL INTAKE USE ONLY</p> <p><input type="checkbox"/> Consent Valid (signed within the last year)</p>
