LAST NAME (FIRST)

MRN VISIT NUMBER

DATE OF BIRTH YYYY-MM-DD SEX

ADDRESS

IMPRINT OR ENTER DETAILS BY HAND

TeleLink Mental Health Program

Follow-up Form

Agency Client #: ____________________ MRN:______________________ Date of Request:____________________ (YYYY - MM - DD)

Referring Agency / Hospital / Physician: ____

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:______________________________

CENTRAL INTAKE USE ONLY

☐ Consent valid (signed within the last year)