Phone : 1(855) 621-0073 | Email : support@kixcare.com

REQUEST FOR PEDIATRIC VIRTUAL CONSULTATION

PATIENT INFORMATION

Name: _____ _____
Last First

Date of Birth: _____ ☐ **Male** ☐ **Female** ☐ **Other**
DD/MM/YYYY

Address: _____ _____ _____ _____
Street Number Street Name City Postal Code

Phone: _____ **Email:** _____

Health Card: _____ _____
Card Number VC or Exp Date

REASON FOR REQUEST:

_____

_____

_____

_____

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_____

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_____

PRIORITY ☐ **LOW** ☐ **MEDIUM** ☐ **HIGH** ☐ **URGENT**

REFERRING PRACTITIONER

Name: _____ **Practitioner billing number:** _____

Phone: _____ **Fax:** _____

Signature: _____ **Date:** _____

PLEASE FAX TO

1-888-251-4004