REQUEST FOR PEDIATRIC VIRTUAL CONSULTATION

PLEASE FAX FORM TO 1-888-251-4004 OR EMAIL TO REFERRALS@KIXCARE.COM

PATIENT INFORMATION

Name: _____

Last First

Date of Birth: _____ ☐ **Male** ☐ **Female**

DD/MM/YYYY

Address: _____

Street Number Street Name City Postal Code

Phone: _____ **Email:**_____

Healthcard number:_____

REASON FOR REQUEST:

_____

_____

_____

_____

_____

_____

_____

_____

SUGGESTED DELAY _____

REFERRED BY

Name: _____ **Physician billing number:** _____

Phone: _____ **Fax:** _____

Signature: _____ **Date:** _____

PLEASE FAX OR EMAIL REFERRAL TO

1-888-251-4004
OR
REFERRALS@KIXCARE.COM
***Referrals also accepted through www.oceanhealthmap.ca**

Phone : (416) 343-0061 | Fax : 1(888) 251-4004 | Email : support@kixcare.com