ECONSULTS CANADA

E-Consult Request
Fax 1-844-729-4783

PLACE PATIENT LABEL HERE				DOB:
First name:		Last name:		Phone(C):
Address:			Gender:	Phone(H):
City:	Province:		Postal Code:	Email:
PHN:	PHN Prov.:			

A. E-CONSULT *only*			PLEASE ATTACH THE FOLLOWING:
Choose the AREA OF EXPERTISE (required)			
☐ Dermatology	☐ Internal Medicine	☐ Orthopedics	☐ Patient Summary
☐ Pediatric Plastic Surgery	☐ Physiatry	☐ Psychiatry	
☐ Rheumatology	☐ Sports Medicine	☐ Chronic Pain	☐ Medication list
☐ Opioid Reduction	☐ Weight Management	☐ Others	☐ No meds
			☐ Lab Results
☐ Initial Request	☐ Follow Up		☐ None
E-consult question? (required)			☐ Imaging Reports
			☐ None
			☐ Others
			(Consult reports, discharge summaries, procedures etc.)
			NOTES:

B. E-CONSULT WITH TREATMENT PLAN (choose the Treatment Plan for your Patient)			
☐ Initial Request	☐ Follow Up		
☐ Anxiety	☐ Chronic Pain	☐ Diabetes	
☐ Insomnia	☐ Migraine	☐ Osteoarthritis	
☐ Weight Management	☐ Other		
Musculoskeletal (MSK)			
☐ Post-injection (modifier)			
☐ Cervical Pain (C/S)	☐ Thoracic Pain (T/S)	☐ Lumbar Pain (L/S)	☐ Sacroiliac Pain (SI)
☐ Shoulder Pain	☐ Elbow Pain	☐ Wrist Pain	☐ Carpal/Hand Pain
☐ Hip Pain	☐ Knee Pain	☐ Ankle Pain	☐ Tarsal/Foot Pain

REQUESTER'S INFORMATION		
Name:		
Practitioner's ID/Stamp:		Physician's Signature
Clinic:		
Phone:	Fax:	
Address:		Data of Request (dd/mmm/yy)

Sample

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