Ontario eConsult Program

Primary Care Intake Form

First Name: _____ **Last Name:** _____

Profession: _____

CPSO # or CNO# _____ **OHIP Billing #:** _____

Account type: ☐ Associated with organization ☐ Solo Account

Organization (if applicable): _____

Address: _____

City: _____

Phone (incl. extension): _____ **Postal Code:** _____

ONE ID Account: _____

Email: _____

Delegate Name (if applicable): _____

Delegate email (if applicable): _____

Once complete, please forward to:

The SEAMO Digital Health Team

seamo.digitalhealth@queensu.ca

Disclaimer: By providing this information you confirm that the Ontario eConsult Centre of Excellence may collect, use and disclose this information in order to follow-up with you and/or support you with signing up for the Ontario eConsult Program. This may include disclosing this information to other relevant parties in order to provide you with the requested services.