# 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:***

*Ontario eConsult Centre of Excellence*

*eConsultCOE@toh.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.*