eConsult
Ontario eConsult Program

# Ontario eConsult Program

## Specialist Intake Form

First Name: ______________________ Last Name: ______________________

Specialty/Sub-specialties: ______________________

CPSO # ______________________ OHIP Billing #: ______________________

Account type: ☐ Associated with organization ☐ Solo Account

Organization (if applicable): ______________________

Address: ______________________

______________________

City: ______________________

Phone (incl. extension): ______________________ Postal Code: ______________________

ONE ID Account: ______________________

Email: ______________________

***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.*