Ontario eConsult Program

Primary Care Intake Form

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

Profession: _____

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

Account type: ☐ Associated with organization ☐ Solo Account

Which EMR are you using: _____

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

Email: eConsultCOE@toh.ca

Fax: 1-613-738-8391

For more information, visit our website **www.eConsultOntario.ca**

or contact us at **eConsultCOE@toh.ca**, or by phone at **1-833-738-8400**

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.