MBTelehealth®

# eConsult
## Intake Form - New Specialist

### PART 1: CONTACT INFORMATION

SPECIALIST NAME

DATE OF REQUEST (DD/MM/YYYY)

CLINIC NAME

**CLINIC (OFFICE) ADDRESS**

UNIT

STREET NUMBER

STREET NAME OR POST OFFICE BOX NUMBER

POSTAL CODE

CITY/TOWN

CLINIC TELEPHONE NUMBER

CLINIC FAX NUMBER

EMAIL

**PRIMARY/ALTERNATE CONTACT INFORMATION:** Person that may assist in working with Manitoba eHealth during implementation

LAST NAME

FIRST NAME

DAYTIME TELEPHONE NUMBER

JOB TITLE/POSITION

EMAIL

### PART 2: BACKGROUND

Briefly describe the background of physician(s): (specialty, practice location, MBTelehealth experience)

### PART 3: INTENDED SERVICE AND IMPACT

Describe the specialty service you intend to provide using MBT eConsult:

What are the expected benefits, outcomes or the impact on patients?

## PART 4: FUNDING

A licensing fee may be required, do you have funding for this?

## PART 5: ADMINISTRATIVE

Is the site owned and operated by:

☐ Manitoba RHA Indicate which RHA: _____

☐ CancerCare Manitoba ☐ Diagnostic Services of Manitoba ☐ Federal

☐ First Nations ☐ Fee For Service ☐ Provincial ☐ Other (describe): _____

## PART 6: APPLICATION APPROVAL

All applications must be approved by the appropriate authority for the site prior to submission (e.g. CEO, Program Director, Clinic Owners). Please indicate the name and title of that person below:

**Please print name:** _____ **Title:** _____

**Send completed form to:**

MBTelehealth
772-715 McDermot Ave.
John Buhler Research Centre
Winnipeg MB R3E 3P4
**Email:** servicedesk@manitoba-ehealth.ca
**Fax:** 1-204-975-7787

**For more information:**

**Website:** www.mbtelehealth.ca
**Phone:** 204-940-8500 Option 4
(toll-free) 1-866-999-9698 Option 4

Submit Form Print Form