

PROVIDER LAST NAME

PROVIDER FIRST NAME

PROVIDER SPECIALTY

PROVIDER HEALTH REGION

WRHA Interlake Eastern Prairie Mountain Southern Health-Santé Sud Northern Other

PROVIDER PHONE NUMBER

This number will be included on the **Telehealth Notification Letter** and can be used by the client and far end MBTelehealth site staff to contact the provider's office to obtain additional information or make any changes to the appointment.

TYPE OF CLIENT

Does the provider see adult or pediatric clients? (check the appropriate box, or both if applicable)

Adult

Pediatric

PROFESSIONAL DESIGNATION

MD RN SLP PT OT RD Other

PREFERRED MBTELEHEALTH SITE(S)

PREFERRED ROOM(S) CODEC

If unsure, please contact your local MBTelehealth Digital Solutions Facilitator or Program Services Representative.

CLERK/NURSE (PRIMARY CONTACT)

Name

Phone #

Email

Required field: All event notifications, modifications and cancellations will be emailed to this address.

CLERK/NURSE (SECONDARY CONTACT)

Name

Phone #

Email

FAX NOTIFICATIONS REQUIRED

No Yes Fax #

Fax machines must be checked/managed regularly by the clerk. Fax notifications are not mandatory.

Completed by:

Date:

Reviewed by:

Date: