 **Physician and Allied Health Orders**

Client Name: Date of Birth (yyyy/mm/dd):

Physician/Provider: \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please sign the telephone order obtained from you on Click or tap to enter a date.. Please fax the signed orders to CNRO at 613-236-7302.

**Nurses Comments/Telephone order**

Nurses name (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Forwarded to Physician for signature:

Mail

Fax

Sent with client to appointment Date:

**Physician's Orders**

Physician Signature: Date:

CLE16 JUNE 2010