** REQUEST FOR TELEHEALTH APPOINTMENT**

 Please fax completed form to 709-752-6057 for processing

Any questions please contact 709-752-6019 / 6071

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **APPOINTMENT INFORMATION** *revised 2016-05-04*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|

|  |
| --- |
|  |

|  |  |  |
| --- | --- | --- |
|  |  |  |

 Date of Consult Duration (minutes) Appointment Start Time |  | **Time Zone: □ NL □ Labrador** |

Appointment Type: □ New Patient **□** Follow-up □ Pre-op □ Post-op □ Case Conference □ Discharge Planning

|  |  |  |
| --- | --- | --- |
|  |  |  |

 Requesting Health Care Provider (**Please Print**) Discipline Clinical / Program Area

|  |  |  |
| --- | --- | --- |
|  |  |  |

Video Request Contact Contact Phone # Email Address Requested to attend with Patient: **□** RN **□** Physiotherapist **□** Occupational Therapist **□** Social Worker **□** None Required □ Other

|  |  |  |
| --- | --- | --- |
|  | **Telehealth Locations** |  **Contact Name and phone number** |
| Health Care Provider Facility  |  |  |
| Patient Location/Facility |  |  |
| Additional Sites (if applicable) |  |  |

**PATIENT INFORMATION (If more than 1 patient attach patient list)**

|  |  |
| --- | --- |
|  |  |

Name (First/Last)  **Please Print** Date of Birth DD/MM/YYYYY

|  |  |  |
| --- | --- | --- |
|  |  |  |

Place of Residence (Mandatory) Province Postal Code

|  |  |  |  |
| --- | --- | --- | --- |
| MCP # |  | Other: (please specify) |  |

 **PROVIDER INFORMATION (complete if attending provider is OUTSIDE of Newfoundland and Labrador)**

|  |  |
| --- | --- |
|  |  |

NL Family/Referring Provider (First/Last Name) **Please Print**  Telephone (xxx) xxx-xxxx |
| **ADDITIONAL RELEVANT INFORMATION****Please select requirements below:** **\_\_\_\_\_\_ Height (cm)**  **\_\_\_\_\_\_ Hand held camera** **\_\_\_\_\_\_ Weight (kg)**  **\_\_\_\_\_\_ Blood Pressure Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_ Vital Signs** | **Comments**Please provide additional information as appropriate (escort or type of assists necessary, gait assessment, oxygen dependent, stretcher required for patient assessment, etc). |