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 2019-06-04

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 ☐ Home Based TH*

**If Home Based Telehealth (TH) appointment requested, please provide patient's email address in the patient 'Patient Information' section below*

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 ______ Email Address (*required for Home Based TH) ______

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)**

______ **Weight (kg)**

______ **Blood Pressure**

______ **Vital Signs**

______ **Hand held camera**

Other: ______________________

Comments

Please provide additional information, as appropriate (escort or type of assists necessary, gait assessment, oxygen dependent, stretcher required for patient assessment, etc.).

Newfoundland and Labrador
TELEHEALTH PROGRAM