



**DO NOT EMAIL THIS FORM AS IT CONTAINS PERSONAL HEALTH INFORMATION**

**\*\*\* BOLDED FIELDS ARE REQUIRED \*\*\***

**Is this for a Televisitation event?** Yes No *If yes, ONLY complete Client Information and Televisitation sections.*

**CONSULTANT INFORMATION**

<b>Consultant LAST Name</b>	<b>Consultant FIRST Name</b>	<b>Specialty</b>	
<b>Consultant Telehealth Site</b>	Room/Codec VCU#	Teams Videoconference ID (10 digits) <i>(from Outlook calendar invite)</i>	
<b>Appointment Date</b>	<b>Start Time (24hr)</b>	<b>End Time (24hr)</b> <i>Central Standard Time/Central Daylight Time</i>	
<b>Booking Contact Name</b>	<b>Contact Phone #</b>	<b>Booking Contact Email</b>	<b>Booking Contact Fax</b>

**CLIENT INFORMATION**

<b>Client LAST Name</b>	<b>Client FIRST Name</b>	<b>PHIN #</b>	Provincial Health # or Other
<b>DOB</b>	Male Female Unknown Undifferentiated		
<b>Address (City/Town)</b>	<b>Postal Code</b>	<b>Phone</b>	
Client Telehealth Site <i>(if unsure - leave blank)</i>	Room/Codec VCU#	Body part to be visualized	
Additional Requirements (check all that apply)	Otoscope	Hand Held Camera	
Client Contact Person (if not client)	Phone	Relationship	

**NOTES AND COMMENTS**

Notes/Additional Comments
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**TELEVISITATION REQUESTS "ONLY"**

Televisitation is for clients receiving care away from home to visit family members in their home community. Must be requested by health-care professional.			
Visitor LAST Name	Visitor FIRST Name	Visitor Location Site	Visitor Phone #
Preferred dates/times (Provide two possible dates/times)			
Date #1 Time (24hr)	Date #2 Time (24hr)	# attending Visitor Site	
Request by: LAST and FIRST Name	Program/Dept	Phone	
<i>(Health-care professional)</i>			