Patient Telehealth Information Form

Prior to telehealth services being rendered, this form must be completed. A copy will be provided to the patient/family, as well as placed into the patient's medical record. Provided information must be accurate, may be verified by the provider or another appointed designee through the organization, and will be utilized to ensure the safety of all parties. If the treating provider determines there is a justifiable reason to break confidentiality to ensure the safety of the patient or another person due to the patient's behavior, the provider is authorized to do so. Conditions for breaking confidentiality may include, but are not limited to: if the patient is determined to be an active harm to themselves or to another, if abuse is recognized, or for a medical or behavioral emergency. If confidentiality must be broken, the treating provider will make reasonable efforts to inform the patient/parents prior to or following the disclosure, as allowed.

General Contact Information:

Patient Name: _____

Legal Guardian Name: _____ Relationship to Patient: _____

Patient Home Address: _____ Best Phone Number to Reach Family: _____

_____

Emergency Contact Information:

Best Alternative Contact Person 1: _____ Relationship to Patient _____

Best Phone Number to Reach: _____

Best Alternative Contact Person 2: _____ Relationship to Patient _____

Best Phone Number to Reach: _____

Nearest Medical Center Name: _____

Nearest Medical Center Address: _____ Phone Number: _____

_____

Nearest Police Department Name: _____

Nearest Police Department Address: _____ Phone Number: _____

_____

Please See Reverse for Additional Information

Emergency Plan:

- **If there is no fear of harm to patient or another person,** the patient/family is asked to write down information to be discussed at the next session. Should more immediate responses be required, the patient/family may call or email the provider. Depending on the nature of the information, the provider may require either a brief phone meeting, or an additional session to manage situations. If the provider deems email appropriate, an encrypted email client will be used.

- **If there appears to be a possibility of harm to the patient or to another person**, the patient/family is to immediately go to the local medical center/emergency room listed on this form. They are asked to contact the provider after safety has been ensured. If the patient/family is closer to another medical center than what is listed, they are to go to that location. Following stabilization and discharge, the patient/family is to provide the provider with an indication of what led to the need for a hospital visit, details of the hospital stay (e.g., medications, diagnoses, treatment summary), and both emotional and behavioral status post-discharge.

- **Note: At any time, the provider can decide that telehealth services are no longer appropriate and as such, may be terminated. If such an event occurs, the provider will provide alternative referral options should face-to-face treatment not be possible.**

Patient Printed Name: _____

Patient Signature: _____

Parent/Legal Guardian Printed Name: _____

Parent/Legal Guardian Signature: _____

Provider Printed Name: _____

Provider Signature: _____