Attachment 2: » » » » » » » »

Patient Encounter Forms

PROJET DE TÉLÉSANTÉ POUR LES PREMIÈRES NATIONS: La Romaine

CODE DU PATIENT :_____ **DATE DE LA VISITE :** ____ — ____ — ____
Personne ayant rempli le formulaire :_____

Heure du début d'utilisation du système de télésanté : _____

Heure de fin d'utilisation du système de télésanté :_____

QUEL EST LE BUT DE LA VISITE DU PATIENT AU CENTRE DE SANTÉ?

- ❑ problème urgent
- ❑ suivi médical or chirurgical, ou vérification des médicaments
- ❑ problème de santé
- ❑ examen de prévention habituel
- ❑ autre :_____

POURQUOI A-T-ON UTILISÉ LE SYSTÈME DE TÉLÉSANTÉ?

- ❑ confirmation de diagnostic
- ❑ justification d'un transfert
- ❑ suivi habituel
- ❑ gestion du cas sans transfert
- ❑ demander rendez-vous
- ❑ y-a-t-il eu une rencontre antérieure à l'aide du système de télésanté? _____ si oui, quand? _____
- ❑ autre raison (spécifier) :_____

LES DONNÉES DE TÉLÉSANTÉ ONT ÉTÉ TRANSFÉRÉES PAR :

- ❑ infirmier/infirmière (nom) _____
- ❑ technicien/technicienne (nom) _____
- ❑ médecin (nom) _____
- ❑ le patient
- ❑ autre : _____

QUI A REÇU LES DONNÉES DU SYSTÈME DE TÉLÉSANTÉ AU SITE ÉLOIGNÉ?

- ❑ infirmier/infirmièreo médecin de famille
- ❑ médecin spécialiste (quelle spécialité?)_____
- ❑ autre? _____
- ❑ à quel(s) site(s)? _____

Si le service de télésanté n'était pas disponible, qu'est-ce qui arriverait à ce patient aujourd'hui?

- ❑ Aucun service _____
- ❑ Attente de la visite du médecin/spédialiste à La Romaine
- ❑ Transfert du patient ailleurs _____
- ❑ Autre _____

QU'EST?CE QUI DOIT ÊTRE FAIT MAINTENANT?

- ❑ Aucune autre mesure n'est requise
- ❑ Un suivi est requis
- ❑ Autre : _____
- ❑ Le patient doit être transféré
- ❑ Le patient doit être revu par le service de télésanté

LE SYSTÈME DE TÉLÉSANTÉ A ÉTÉ UTILISÉ À QUELLE FIN?

- ❑ Données transférées par le patient, porteur d'un glucomètre
- ❑ Système utilisé pendant une visite au centre de santé. Préciser la raison _____ _____ _____ _____
- ❑ ECG. Préciser la raison : _____ _____ _____ _____ _____ _____ _____ _____ _____

Examen particulier :

- ❑ oreilles
- ❑ nez
- ❑ gorge
- ❑ bouche
- ❑ autre: _____ _____ _____ _____ _____ _____

Préciser: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____

Y-A-T-IL EU DES PROBLÈMES DE LOGISTIQUE OU DE COORDINATION LORS DE L'UTILISATION DE LA TÉLÉSANTÉ?

- ❑ Non
- ❑ Ouipréciser la raison : _____

Y-A-T-IL EU DES PROBLÈMES EN CE QUI CONCERNE. . . .

- ❑ le fonctionnement de l'équipement?
- ❑ l'enregistrement ou l'entreposage des données?
- ❑ l'interprétation par le personnel du site éloigné?
- ❑ l'accès au système de télésanté?
- ❑ le temps de transmission?
- ❑ la transmission des données?
- ❑ la qualité de l'image?
- ❑ Autre : _____

RENSEIGNEMENTS SUPPLÉMENTAIRES SUR LE PATIENT :

SVP ENVOYER LE FORMULAIRE DÛMENT REMPLI AU NUMÉRO DE TÉLÉCOPIEUR 514-398-1531.
Pour toute question, appeler au 514-398-3247.

SOUTHEND TELEHEALTH
SESSION FORM
FAX TO: 514-398-1531

DATE OF VISIT: _____ — _____ — _____ **PERSON COMPLETING FORM**: _____
TIME SESSION BEGAN: _____ Time telehealth system connected: _____
Time telehealth system disconnected: _____ TIME SESSION ENDED: _____

WHY WAS THE TELEHEALTH SYSTEM USED?

❑ Patient care: FILL IN BOX 1
❑ Patient education: FILL IN BOX 2
❑ Staff/community education or development : FILL IN BOX 3
❑ 0ther: WRITE DETAILS ON BACK OF FORM

BOX 1: PATIENT CARE **PATIENT CODE:**_____

❑ urgent health problem OR ❑ non-urgent health problem

Who was there at the telehealth session?

In Southend

❑ Patient
❑ Health centre nurse
❑ CHR
❑ Mental health worker
❑ Physician
❑ Translator
❑ Family Member
❑ Other: _____

Other site: where? _____

❑ Family physician
❑ Psychologist
❑ Specialist Type: _____
❑ Nurse
❑ Health educator
❑ Social worker, counselor
❑ Translator
❑ Family Member
❑ Other: _____

What was done during the session?

❑ Specialist consult
- ❑ to discuss or confirm diagnosis
- ❑ to follow up on previous visit
- ❑ to discuss case management
- ❑ Other: _____

Other patient care: describe : _____
_____
_____
_____
_____
_____

What will happen next?

❑ No further action is required
❑ Follow-up is required
- ❑ with telehealth
- ❑ without telehealth

Patient is to be transferred to: _____
Other:_____
Did this session result in avoiding a patient transfer?
❑ Yes ❑ No ❑ Maybe

BOX 2: PATIENT EDUCATION

❑ individual OR ❑ group session → how many attended? _____ Where? ❑ Telehealth office OR ❑ Mental health room

What was done during the session?

❑ Diabetes education → what topics?
- ❑ Diet/nutrition
- ❑ Smoking
- ❑ Insulin
- ❑ Foot care
- ❑ Hypertension
- ❑ Exercise
- ❑ Alcohol
- ❑ Glucose monitoring
- ❑ Counseling or support
- ❑ Other: _____

❑ Other patient education → what topics? _____
_____
_____
_____
_____
_____

BOX 3: STAFF/COMMUNITY EDUCATION OR DEVELOPMENT

Who was there at the telehealth session?

In Southend ***Other site: where?*** _____

❑ Staff : how many? __
❑ Community members: how many? _____

❑ Translator
❑ Other: _____

❑ Psychologist
❑ Diabetes educator
❑ Other educator
❑ Nurse

❑ Social worker, counselor
❑ Translator
❑ Family Member
❑ Other: _____

What topics were covered during the session?

Briefly describe: _____
_____

WERE THERE ANY PROBLEMS IN SCHEDULING OR COORDINATING THE TELEHEALTH VISIT?

❑ No ❑ Yes → Describe: _____

WERE THERE ANY PROBLEMS IN SCHEDULING OR COORDINATING THE TELEHEALTH VISIT?

❑ Establishing communication?
❑ No ❑ Yes → _____

At what speed were you able to connect?

❑ 112 ❑ 128 ❑ 168 ❑ 224
❑ 256 ❑ 336 ❑ 384

Maintaining communication?

❑ No ❑ Yes → _____

❑ Operating the camera?
❑ No ❑ Yes → _____

❑ Sound quality?
❑ No ❑ Yes → _____

❑ Visual quality?
❑ No ❑ Yes → _____

❑ Other technical problems? _____

ADDITIONAL COMMENTS ON THIS TELEHEALTH SESSION

PLEASE FAX THE COMPLETED FORMS TO: 514-398-1531
IF YOU HAVE ANY QUESTIONS OR COMMENTS PLEASE CALL GENEVIEVE AT 514-398-3247

BERENS RIVER
TELEHEALTH SESSION FORM
FAX TO: 514-398-1531

PATIENT CODE: _____ **PERSON COMPLETING FORM:** _____
DATE OF VISIT: _____ — _____ — _____ Time telehealth system connected: _____
Time telehealth system disconnected: _____ TIME SESSION ENDED: _____

WHY WAS THE TELEHEALTH SYSTEM USED?

❑ Patient care: BOX 1 ❑ Patient education: BOX 2 ❑ Continuing education: BOX 3 ❑ 0ther: WRITE ON BACK OF FORM

BOX 1: PATIENT CARE ❑ urgent health problem OR ❑ non-urgent health problem

Who was there at the telehealth session?

In Berens River

- ❑ Patient
- ❑ Health centre nurse
- ❑ CHR
- ❑ Mental health worker
- ❑ Physician
- ❑ Translator
- ❑ Family Member
- ❑ Other: _____

In Winnipeg

- ❑ Infectious disease specialist
- ❑ Psychiatrist
- ❑ Pediatrician
- ❑ Gynecologist/obstet.
- ❑ Nurse
- ❑ Health educator
- ❑ Social worker, counselor
- ❑ Translator
- ❑ Family Member
- ❑ Other: _____

What was done during the session?

- ❑ Specialist consult
  - ❑ to discuss or confirm diagnosis
  - ❑ to follow up on previous visit or on test results
- ❑ to discuss case management (medication review/adjustment)
  - ❑ Other: _____
- ❑ Prenatal care
- ❑ Other patient care: describe :_____

What will happen next?

- ❑ No further action is required
- ❑ Follow-up is required
  - ❑ with telehealth
  - ❑ without telehealth
- ❑ Patient is to be transferred to: _____
- ❑ Other:_____
- ❑ Did this session result in avoiding a patient transfer?
  - ❑ Yes ❑ No ❑ Maybe

BOX 2: PATIENT EDUCATION

❑ individual OR ❑ group session → how many attended? _____

What was done during the session?

- ❑ Diabetes education → what topics?
  - ❑ Diet/nutrition
  - ❑ Smoking
  - ❑ Insulin
  - ❑ Foot care
  - ❑ Hypertension
  - ❑ Exercise
  - ❑ Alcohol
  - ❑ Glucose monitoring
  - ❑ Counseling or support
  - ❑ Other: _____
- ❑ Other patient education → what topics? _____

BOX 3: CONTINUING EDUCATION ❑ individual OR ❑ group session → how many attended? _____

Who was there at the telehealth session?

In Berens River

- ❑ Staff : how many? _____
- ❑ Community members: how many? _____
- ❑ Translator
- ❑ Other: _____

In Winnipeg

- ❑ Specialist
- ❑ Psychologist
- ❑ Diabetes educator
- ❑ Other educator
- ❑ Nurse
- ❑ Social worker, counselor
- ❑ Translator
- ❑ Other: _____

What topics were covered during the session?

Briefly describe:

_____

WERE THERE ANY PROBLEMS IN SCHEDULING OR COORDINATING THE TELEHEALTH VISIT?

❑ No ❑ Yes → Describe:

_____

WERE THERE ANY PROBLEMS WITH…?

❑ Establishing communication?
❑ No ❑ Yes → _____

❑ Maintaining communication?
❑ No ❑ Yes → _____

❑ Operating the camera?
❑ No ❑ Yes → _____

❑ Sound quality?
❑ No ❑ Yes → _____

❑ Visual quality?
❑ No ❑ Yes → _____

❑ Other technical problems? _____

SUMMARY OF DOCTOR'S COMMENTS

_____

_____

_____

_____

_____

ADDITIONAL COMMENTS ON THIS TELEHEALTH SESSION

_____

_____

_____

_____

_____

PLEASE FAX THE COMPLETED FORMS TO: 514-398-1531

IF YOU HAVE ANY QUESTIONS OR COMMENTS PLEASE CALL 514-398-3247

Telehealth Research Project
In Fort Chipewyan, Alberta

Monthly Report for the Month of _____

DESCRIPTION	STATS
TOTAL NUMBERS FOR THE MONTH	
• Total number of sessions for the month	
• Total number of rehabilitation clients seen this month	
• Total number of patients that used Televisitation	
• Total number of family/friends that used Televisitation	
SPEECH THERAPY	
• Total number of Speech sessions	
• How many of these were Telehealth	
• Total number of Speech clients seen this month	
PHYSIOTHERAPY	
• Total number of Physiotherapy sessions	
• How many of these were Telehealth	
• Total number of Physiotherapy clients seen this month	
OCCUPATIONAL THERAPY	
• Total number of Occupational sessions	
• How many of these were Telehealth	
• Total number of Occupational clients seen this month	
TELEVISITATION	
• Total number of Televisitation sessions	
• Total number of maintenance/tests/demos of Telehealth sessions	

PROGRESS NOTES:

A= Initial Assessment
B= Ongoing Therapy
C= Adjustment of Therapy
D= Reassessment
E= No therapy needed
F= Discharged
G= Other

SLP Clients	PT Clients	OT Clients
ST -	**PT-**	**OT -**