Avery telehealth

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Fax: (866) 664-8892
www.averytelehealth.com

TELEHEALTH INTAKE FORM

Referring Agency:	Referring Agency Phone:
Contact:	Referring Agency Fax:

Patient Name:	Physician Name:
Patient DOB:	Physician Address:
Patient Address:	
	Physician Phone:
Patient Phone:	Physician Fax:

Primary Diagnosis:	☐ CHF ☐ COPD ☐ HYPERTENSION ☐ OTHER
	☐ Diabetes ☐ Diet Controlled only ☐ AMI ☐

Equipment needed	BP monitor :	Pulse ox:
Test strips: Glucometer :	Scale :	HUB :

Additional Comments

Name (print):		
Signature:		
Date:	Time:	

PLEASE COMPLETE AND FAX TO 866-664-8892
IF YOU HAVE A MEDICATION LIST, PLEASE INCLUDE

CONSENT TO PARTICIPATE IN TELEMEDICINE

Patient's Name: _____ Date: _____
Date of Birth: _____

1. I understand that my health care provider/ physician, _____, is aware that I have agreed to participate in telehealth/ telemedicine. This means that Avery Telehealth will be able to manage my treatment protocol using telecommunications and equipment.
2. Avery Telehealth has explained to me how to use the telehealth technology that will be used as an adjunct to my current plan of treatment ordered by my physician.
3. Telemedicine has been explained to me and how the telehealth program will assist my healthcare provider in better managing my disease.
4. I am aware that my healthcare information may be shared with other individuals for scheduling and business purposes.
5. In an emergent case, I understand that telehealth is not to replace the 911 Call and/or AN EMERGENCY CALL. I understand that if I need to speak with my healthcare provider, I should call them at their office.
6. I agree to answer questions about my condition, my treatment and medicines. I will not blame Avery Telehealth if I do not provide true and honest answers.
7. I will follow the guidelines and instructions given to me regarding the safe use of the Telehealth equipment by Avery Telehealth. If telehealth equipment is left in my house, I will be careful with it. I promise to return it in the same condition as when it was left. I agree to pay for any damages, repairs or replacement of any telehealth equipment not returned.
8. Questions that I may have regarding the equipment or use of the equipment for my medical care have been answered to my satisfaction.

I have read this consent carefully and understand all the contents of this consent. I agree that the equipment is in good working condition and I agree to return it in the same condition. I hereby consent to participate in a treatment care telehealth program under the terms described herein. I hereby consent to have Avery Telehealth contact my personal physician to obtain treatment protocols.

Patient Signature: _____ Date/Time: _____

Person with legal right to sign if patient unable: _____
Date: _____

Witness: _____
Date: _____

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