

**Upper Peninsula Telehealth Network
Telemedicine Documentation Form**

Date _____

Telemedicine Site _____

Name _____
Address _____
Phone _____
MRN _____

Diagnosis _____ Reason for Consult _____

Specialist/Practitioner _____ Local Practitioner _____

Admit at _____ AM/PM Consult time _____ AM/PM to _____ AM/PM

? Procedure explained

Equipment

? Consents/authorizations signed

? Patient Exam Camera

? Stethoscope

? CXR ? CXR N/A

? Document Camera

? Viewbox

? Labs ? Labs N/A

? Other _____

Persons at encounter

Near End _____

Far End _____

Vital signs/measurements: N/A _____ B/P _____ Temp. _____ Pulse _____ RR _____
Lungs _____ Wt _____ Ht _____ Pain _____
Other _____

Incision(s)/Wounds _____ (location)
Comments: _____

Medications: _____

Allergies _____

Comments: _____

RN/LPN/Staff Signature _____ Date/time _____