



TELEMEDICINE ASSESSMENT

Infectious Diseases Clinic
Please FAX to 613-761-4055
(15 minutes prior to appointment)

Date (yyyy/mm/dd):		Time:	
Patient name	DOB	OHIP no	
Nurse contact name	Phone	Fax	
Pharmacy name	Phone 613-	Fax 613-	
Laboratory name	Phone	Fax	
Family physician name	Phone	Fax	

Presence of: Wound Yes No Skin issues Yes No IV access Yes No
If you answered yes, please have handheld camera ready.

			For new patient please take		
BP	P	R	Oximeter	Height	Weight
Right arm	Left arm		%	cm	kg

ALLERGIES	MEDICATIONS	Dose	Route	Frequency
1	1			
2	2			
3	3			
4	4			
5	5			
6	6			
7	7			
8	8			
9	9			
10	10			
11	11			
12	12			
13	13			
14	14			

Comments

NOT TO BE INCLUDED IN HEALTH RECORDS