UVA Health

Karen S. Rheuban Center for Telehealth
Facility Telemedicine Consult Service
v20201215-lo

REQUEST FOR TELEMEDICINE CONSULTATION
SPECIALTY CONSULT SERVICES: Fax form to (434) 244-7521

Scheduling Contact Line: (434) 924-5470

Note: For emergency or urgent acute care needs, call 911 or use internal facility treatment protocol

Requesting Facility:	

New Patient: Please complete in full
Returning Patient: Please include Name, Email, DOB, and UVA Medical Record Number

Patient Name: _____ Date of Birth: _____

Patient Email: _____ UVA MRN: _____ SSN: _____

Primary Insurance: _____

Secondary Insurance: _____

Requesting LIP & Title: _____

LIP Call Back #: _____ Facility Nursing Station #: _____

Specialty Request: _____ Provider Name Request: _____

Reason for Request: _____

COVID Support Request - Skilled Nursing/Long Term Care Facility (SN/LTC)

Is this a COVID-related consultation? ☐ Yes ☐ No Code Status: ☐ DNR ☐ DNI ☐ Full Code

Provide the following information and diagnostic studies, if available:

- Last vitals including pulse-oximetry (required)
- Recent laboratory studies: CBC w/ diff, Chemistry, LFT, troponin, BNP
- Recent microbiology testing: COVID-19 PCR, Flu, viral respiratory panel, Strep, Blood cultures
- Any chest imaging results (CXR and CT)
- Any Pulmonary function testing results
- Any cardiac testing (echocardiogram, EKG)

Documentation Required With Request for Consult	New UVA Patient Requests	Initial Telemedicine Requests	Follow-up Telemedicine Requests	Included/ Completed
Patient Demographics / Registration Information Form	Yes	Yes	Yes	☐
Driver's License / State Identification Card	Yes			☐
Health Insurance Card (copy of front and back)	Yes	Yes	Yes	☐
Patient History/Notes, Full Medication List (MAR), Labs	Yes	Yes	Yes	☐
HIPAA Form	Yes			☐
LTS Green Card (mail originals to UVA Telemedicine)	Yes			☐
Telemedicine Consent Form	Yes			☐
Patient and Family Education Handout	No copy needed, handout for patient / family			☐
Documentation of Surrogate Verbal Consent (SN/LTC *patients without decision-making capacity*)	Yes	Yes	Yes	☐

Appointment Type: ☐ Initial ☐ Follow-Up ☐ Extended Follow-up ☐ E-Consult (for designated pilot facility only)

Request Form Completed By	**Requested Consult Date & Time**	
Name: _____	Date: _____	**SN/LTC Geri/Pulm Request Timeframe**
Date: _____	Time: _____	☐ 8 am – 10 am ☐ 10 am – 12 pm
Time: _____		☐ 12 pm – 2 pm ☐ 2 pm – 5 pm