

Winghaven Pediatrics Telehealth Evaluation Form – Consulting Clinician

Encounter Date: _____

Encounter Start Time:	_____ a.m. _____ p.m.	Encounter Stop Time:	_____ a.m. _____ p.m.
Patient Name:		DOB:	

Clinician's Name:	Location of call:
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1.	How many times you have conducted clinical services on this patient? <input type="checkbox"/> Never <input type="checkbox"/> 1-5 times <input type="checkbox"/> Over 5 times													
2.	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 40%; vertical-align: top;"> The purpose of today's encounter <input type="checkbox"/> Consultation <input type="checkbox"/> Pre-op visit <input type="checkbox"/> Post-op visit <input type="checkbox"/> Ongoing care <input type="checkbox"/> See own patients via telemedicine </td> <td style="width: 60%; vertical-align: top;"> Primary Diagnosis (please circle below) Eczema Other (specify) _____ <div style="text-align: right;">No Diagnosis</div> </td> </tr> </table>	The purpose of today's encounter <input type="checkbox"/> Consultation <input type="checkbox"/> Pre-op visit <input type="checkbox"/> Post-op visit <input type="checkbox"/> Ongoing care <input type="checkbox"/> See own patients via telemedicine	Primary Diagnosis (please circle below) Eczema Other (specify) _____ <div style="text-align: right;">No Diagnosis</div>											
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3.	Was a definitive diagnosis established? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA													
4.	Technology adequate to make diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA													
5.	In-person visit required for diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA													
6.	Was a definitive treatment plan established? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA													
7.	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; vertical-align: top;"> Patient disposition: (Select up to three choices) </td> <td style="width: 75%;"> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td>Return to referring clinicians' care</td></tr> <tr><td>Refer to another clinician in patient's community</td></tr> <tr><td>I will manage the patient's care</td></tr> <tr><td>Additional testing needed</td></tr> <tr><td>Discharge patient from care</td></tr> <tr><td>Patient will see me in person</td></tr> <tr><td>Other (specify) _____</td></tr> </table> </td> </tr> </table> <div style="margin-top: 10px;"> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">Patient Disease Category <small>(circle each that apply)</small></td> </tr> <tr> <td> Mental Health Diabetes Asthma Other Chronic Condition _____ </td> </tr> </table> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 5px;"> <tr> <td style="text-align: center;">Patient Age Category</td> </tr> <tr> <td> <input type="checkbox"/> Less than 18 years old <input type="checkbox"/> 18-21 <input type="checkbox"/> More than 21 years old </td> </tr> </table> </div>	Patient disposition: (Select up to three choices)	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td>Return to referring clinicians' care</td></tr> <tr><td>Refer to another clinician in patient's community</td></tr> <tr><td>I will manage the patient's care</td></tr> <tr><td>Additional testing needed</td></tr> <tr><td>Discharge patient from care</td></tr> <tr><td>Patient will see me in person</td></tr> <tr><td>Other (specify) _____</td></tr> </table>	Return to referring clinicians' care	Refer to another clinician in patient's community	I will manage the patient's care	Additional testing needed	Discharge patient from care	Patient will see me in person	Other (specify) _____	Patient Disease Category <small>(circle each that apply)</small>	Mental Health Diabetes Asthma Other Chronic Condition _____	Patient Age Category	<input type="checkbox"/> Less than 18 years old <input type="checkbox"/> 18-21 <input type="checkbox"/> More than 21 years old
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8.	Clinical decision-making was successfully accomplished <table style="width: 100%; text-align: center;"> <tr> <td style="width: 20%;">Strongly Agree</td> <td style="width: 20%;">Agree</td> <td style="width: 20%;">Don't Know</td> <td style="width: 20%;">Disagree</td> <td style="width: 20%;">Strongly Disagree</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
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Any other important items regarding this encounter? _____
