MBTelehealth® A Shared Health Service

CLINICAL BOOKING FORM

MBTelehealth Scheduler
Fax: 1-204-975-7787
Phone: 1-204-940-8500 Option 4, Option 2
Toll-free: 1-866-999-9698 Option 4, Option 2

DO NOT EMAIL THIS FORM AS IT CONTAINS PERSONAL HEALTH INFORMATION

***** BOLDED FIELDS ARE REQUIRED *****

Is this for a Televisitation event? Yes No *If yes, ONLY complete Client Information and Televisitation sections.*

CONSULTANT INFORMATION

Consultant LAST Name **Consultant FIRST Name** **Specialty**

Consultant Telehealth Site Room/Codec VCU#

Appointment Date **Start Time (24hr)** **End Time (24hr)** *Central Standard Time*

Booking Contact Name **Contact Phone #** **Booking Contact Email** **Booking Contact Fax**

CLIENT INFORMATION

Client LAST Name **Client FIRST Name** **PHIN #** Provinical Health # or Other

DOB Male Female Unknown Undifferentiated

Address (City/Town) **Postal Code** **Phone**

Client Telehealth Site *(If unsure - leave blank)* Room/Codec VCU#

Additional Requirements (check all that apply) Otoscope Hand Held Camera Body part to be visualized

Client Contact Person (if not client) Phone Relationship

NOTES AND COMMENTS

Notes/Additional Comments

TELEVISITATION REQUESTS "ONLY"

Televisitation is for clients receiving care away from home to visit family members in their home community. Must be requested by health-care professional.

Visitor LAST Name Visitor FIRST Name Visitor Location Site Visitor Phone #

Preferred dates/times (Provide two possible dates/times)
Date #1 Time (24hr) Date #2 Time (24hr) # attending Visitor Site

Request by: LAST and FIRST Name Program/Dept Phone

(Health-care professional)