Virtual Care for Long Term Care

Consent obtained from resident or SDM (see consent tool): □ Yes, Date: _____ □ No (cannot proceed)
By Whom: _____ Signature: _____

Date & Time of Call	Name of RN Calling	Consulting virtual care physician

The following information is prepared by LTC RN prior to call into virtual care physician		
Resident Demographics	Name	
	Age and DOB	
	Ontario Health Card Number	
	Allergies	
	Weight and Creatinine OR Creatinine Clearance	
	Goals of Care	
	Primary SDM Name and Contact Number	
Situation *Has this resident used eVisit in the last week? Ensure this is reported to the virtual care physician.	**Primary concern(s) and reason for considering hospital transfer**	
	Onset and progression of symptoms & comparison to baseline.	
	Vital Signs	BP: _____ HR: _____ T: _____ RR: _____ O2: _____
	Pain Assessment	
	LOC changes	□ No change □ Decreased □ Increased
	Oral intake	□ No change □ Decreased □ Increased
	Functional changes	□ No change □ Worsened □ Improved
Background *Have all relevant information ready to report. Attach ONLY if sending to ED.	Medical history & diagnoses □ List attached	
	Recent treatments	
	Other medications/ possible interactions □ MAR attached	
	Most recent INR and Coumadin dose	□ Not applicable
	Recent investigations □ Attached	

If resident is transferred to ED
-send a photocopy of this form

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Discussion and Outcomes of virtual care visit (Notes)	
Physical assessment notes during eVisit	
Assessment and Differentials	
Medication Changes	
Diagnostics	
Follow up Required	

If questions arise:

Consulting/eVisit Physician Name: _____

Contact Number: _____

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