

EMERGENCY TELE MEDICINE CONSULT FORM

Pt Medical Record Number: _____ Name: Last _____ MI _____ First: _____

Age: _____ M / F Date of Birth: _____ Consulting SHMC/DEC Physician: _____

Originating Facility: _____ Originating Provider: _____ Date: _____ Time: _____

Mechanism of Injury or History of Illness (HPI): *Timing, Duration, Severity, Influencing factors, Associated signs and symptoms*

Past Med/Surg Hx: _____ **Family Hx:** _____ **Social Hx:** _____

Due to patients medical condition HPI and Past Medical, Surgical, Family and Social History is Limited/or unable to be obtained. _____ MD initial

| | | | | | | |
|-------------------|-------|-----|-----|------|-----------|--------------------|
| Vital Signs: Time | Temp: | HR: | RR: | B/P: | Oximetry: | Pediatric Patient: |
| Initial VS: | | | | | | Ht: |
| Repeat VS: Time | Temp: | HR: | RR: | B/P | Oximetry: | Wt: |

| | |
|---|--|
| Physical Exam: | Imaging: Images personally viewed on Stentor: Y _____ N _____ |
| Constitutional: | CXR: |
| HEENT: | C-spine: |
| Spinal/Cervical Immobilization: Y _____ N _____ | Pelvis: |
| Musculoskeletal: | Extremities: |
| Cardiovascular: | CT Head: |
| Respiratory: | CT Chest: |
| GI: | CT abd/pelvis: |
| GU: | Other: |
| Hema/Lymph: | EKG: |
| Endo: | |
| Skin: | |
| Neuro: | |

| | | | | |
|------------------------|---------------------|------------------|----------------------|--------------|
| Medications: | | | Fluid output: | Labs: |
| Analgesics | Paralytics | Sedatives | Foley: _____ cc | H&H |
| Drug, dose, time | Drug, dose, time | Drug, dose, time | Appear: _____ | ABG's |
| | | | N/G: _____ cc | U/A: |
| | | | Appear: _____ | Other labs: |
| Cardiovascular: | Antibiotics: | Other: | Chest tube: _____ cc | |
| Drug, dose, time | Drug, dose, time | Drug, dose, time | Appear: _____ | |
| | | | Rewarming: | |

Assessment/Diagnosis:

| | |
|--------------------------------|--------------|
| Recommended Management: | Procedures: |
| Treatment: | |
| Imaging: | Medications: |

Transport: BLS: _____ ALS: _____ Air _____ Private vehicle: _____ Other: _____ No transport recommended at this time: _____

Physician signature: _____ **Report back to:** Dr. _____ **Dictated date:** _____