31 Nova Scotia Walk
Elliot Lake, Ontario P5A 1Y9
Fax: 705 461-7543
Phone: 705 461-8882

Virtual Clinic Welcome Package

For non-Rostered Patient

Welcome Patients!

The Elliot Lake Family Health Team is offering the Virtual Clinic program to anyone who does not have a doctor in town. This clinic will allow you to have prescriptions refilled with exception of opioids (please see attached documents), manage chronic disease, obtain specialist referrals, and assist with form completion.

Patients interested in having an appointment must complete the Medical History Consent Form as well as provide a medication list from their pharmacy to be registered before booking an appointment. Patients can call or stop in at the clinic on the 1st floor to book an appointment with a virtual physician that is available.

This clinic is launched for non-rostered patients on a book appointment basis. We sincerely hope this addition to our services is of benefit to you. If you have any questions or concerns, please do not hesitate to contact the clinic. Also, we would like to thank you for your continued patience while we provide this service at our clinic.

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Telemedicine Patient Consent/ Refusal Form, Page 1

Patient Name: ____

Date of Birth: ____

Health Card No.: ____

1. **PURPOSE:** The purpose of this form is to obtain your consent to participate in a telemedicine consultation in connection with the following procedure and/ or service(s):
    i. Virtual Care Clinic Appointment with a virtual physician
2. **NATURE OF TELEMEDICINE CONSULT:** During the telemedicine consultation:
    a. Details of your medical history, examinations, x-rays, and tests will be discussed with other health professionals by interactive video, audio, and telecommunication technology.
    b. A physical examination of you may take place by a Registered Practical Nurse who is present.
    c. A non-medical technician may be present in the telemedicine studio to aid in the video transmission.
    d. Video, audio, and/or photo recordings may be taken of you during the procedure(s) or service(s).
3. **MEDICAL INFORMATION & RECORDS:** All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. Please note not all telecommunications are recorded and stored. Additionally, dissemination of any patient identifiable images or information from this telemedicine interaction to other entities shall not occur without your consent.
4. **CONFIDENTIALITY:** Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation, and all existing confidentiality protections under federal and provincial laws apply to information disclosed during this telemedicine consultation.
5. **RIGHTS:** You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.
6. **DISPUTES:** You agree that any dispute arising from the telemedicine consult will be resolved in Ontario.
7. **RISKS, CONSEQUENCES & BENEFITS:** You have been advised of all the potential risks, consequences, and benefits of telemedicine. Your health care practitioner has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and the telemedicine consultation. All your questions have been answered and you understand the written information provided above.

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Telemedicine Patient Consent/ Refusal Form, Page 2

PATIENT CONSENT:

- ✔ I agree to participate in a telemedicine consultation for the procedure(s) described above on Page 1 of the Telemedicine Patient Consent/ Refusal Form.
- ✔ I understand that I am not a rostered patient of the Elliot Lake Family Health Team but am seeing a Virtual Physician through the Virtual Care Clinic as a patient without a physician at the Elliot Lake Family Health Team.
- ✔ I understand that I must book an appointment for all prescription requests.
- ✔ I understand that I cannot request a narcotic or opioid at the Virtual Care Clinic location at the Elliot Lake Family Health Team.

PATIENT NAME (printed): ____

PATIENT NAME (signature): ____

DATE: ____

If signed by someone other than the patient, indicate relationship: ______________________

REFUSAL OF SERVICE:
I refuse to participate in a telemedicine consultation for the procedure(s) described above:

Signature: ____

If signed by someone other than the patient, indicate relationship: ____________________

WITNESS NAME (printed): ____

WITNESS NAME (signature): ____

DATE: ____

ÉQUIPE SANTÉ FAMILIALE
ELLIOT LAKE
FAMILY HEALTH TEAM

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Medical History Questionnaire

Last Name:	**First Name: (as it appears on your health card)**	**Gender:**
Birth Date:	**Health Card Number:**	
Postal Code:	**Address:**	
Home Phone Number:	**Mobile Phone Number:**	
Email:	**Preferred Method of Contact:**	
Family Members in the Same Household:		
Pharmacy:		

Do you currently smoke? ☐ **No** ☐ **Yes** (How many cigarettes per day? _______)
If you smoked previously, when did you quit (year)? _______________

Please check if you CURRENTLY have any of the following medical conditions and provide details:

- ☐ Anemia _____________________________
- ☐ High Cholesterol ______________________
- ☐ Diabetes ____________________________
- ☐ Heart Disease ________________________
- ☐ Asthma _____________________________
- ☐ COPD _______________________________
- ☐ Crohn's/Colitis/IBS ___________________
- ☐ Kidney Disease _______________________
- ☐ High Blood Pressure __________________
- ☐ Cancer (what type?) __________________
- ☐ Arthritis ____________________________
- ☐ Chronic Pain _________________________
- ☐ Epilepsy ____________________________
- ☐ Thyroid Disease ______________________
- ☐ Bleeding Disorder ____________________
- ☐ Depression/Anxiety __________________

- ☐ Other Medical Conditions ____

PAST Medical Concerns: ____

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Have you ever been hospitalized for surgery or illness? *Please list below:*

Date/Year	Reason

Do any of the following medical conditions run in your family? Who is affected (e.g. father, aunt, etc.)?

☐ Heart Disease ________________________
☐ Cancer (what type?) __________________
☐ Genetic Diseases _____________________
☐ Stroke ________________________________
☐ Diabetes _______________________________
☐ Dementia/Alzheimer's ________________

☐ Other ____

Please list allergies to medication, food, environmental, or other triggers: ☐ **None Known**

Allergy (to medication, food, environmental, etc.)	Reaction (e.g. rash, upset stomach, etc.)

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Medications: Please list all prescriptions, vitamins, over-the-counter, and herbal medications you take on a regular basis. Include pain medication, inhalers, creams, insulin, etc., and "as needed" medications.
(You may attach a list from your pharmacy instead of completing this part of the form.)

Name	Dose	How do you take it?
ex: Atorvastatin	ex. 20 mg	ex. once daily with breakfast

Do you take medications for PAIN, other than those listed above? *(please list if applicable)* ☐ **No**

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When is the last time you had the following immunizations* and screening tests?

Immunization	Date
☐ Tetanus	________________
☐ Pneumonia (PneumovaxⓇ)	________________
☐ Hepatitis A&B (TwinrixⓇ)	________________
☐ Influenza	________________
☐ Shingles (ZostavaxⓇ)	________________
☐ COVID-19 *(specify type)*	________________
☐ Other Immunizations	

**Please provide a copy of the yellow immunization record for children.*

Screening Test	Target Population	Date	Outcome?
Colorectal Cancer ☐ Stool Kit (FOBT/FIT) OR ☐ Colonoscopy	**Everyone** age 50-74		
Cervical Cancer (Pap Smear)	**Women** age 21-69		
Breast Cancer (Mammogram)	**Women** age 50-74		

Previous Family Physician(s) & Contact Information:

____

____

Specialists (Current and Previous; please indicate when you were last seen) & Contact Information:

____

____