Bourassa & Associates

REHABILITATION CENTRE

COVID-19 NEW PATIENT TELEHEALTH FOLLOW UP CONSENT FORM

Date: March 30, 2020

PATIENT INFORMATION

NAME: Loretta Henry
Last:
First:

PATIENT CONSENT

- I consent to being examined and treated via Telehealth. Although we are using all recommended levels of security, it is not possible to be absolutely certain.
- In normal times, treatment may involve the use of various physical and electrical modalities, correction of abnormal function of various body parts by the therapist mobilizing or manipulating joints and tissues, as well as exercise programs aimed at mobility, strength and function.
- During COVID-19, telehealth will consist of the usual history and health inquiry. We may ask you to perform various movements that we will observe via webcam. We will advise of appropriate self management. I understand the limitations of the compromised physical examination and associated risks that recommended management may cause increased symptoms and a limited chance of progression of the condition.
- I understand that there is a risk of soreness with recommended treatment.
- I understand there is a rare risk of advancement or worsening of conditions with recommended treatment.
- This consent has been verbally discussed with me by the assessing therapist
- I understand that I can abort this method of care at any time.
- I understand that both the patient and the therapist will disclose who is listening or watching the Telehealth interaction.

EHEALTH and PRIVATE RADIOLOGY CONSENT

- ehealth is a Saskatchewan Health site that allows access to any records of procedures or consultations done in a public facility. The clinic is a registered facility with ehealth and can access your records on a "need to know" basis.
- Private Radiology servers exist outside ehealth. The clinic is a registered facility with these servers and can access your records on a "need to know" basis.
- I consent to this clinic accessing my records on a need to know basis.

_____See electronic consent_____
Patient Signature

If the client is under 16 years of age the following section of the consent form must be completed by a Parent or Guardian before treatment can be initiated.

I have read and fully understand all of the above information and give my permission to have
_____(Full name of client) assessed and/or treated at Bourassa & Associates Rehabilitation Centre and agree to be responsible for the costs.

_____
Printed Name of Parent or Guardian:

_____ _____ _____
Signature of Parent or Guardian Witness Date

ASSESSING THERAPIST ACKNOWLEDGEMENT OF INFORMED CONSENT DISCUSSION

- The above consent has been explained, line by line, to the patient and the patient was offered an opportunity to discuss any concerns.

_____ _____
Therapist Signature Therapist Name

FOR OFFICE USE ONLY

Verified and entered by:_____ Date entered:_____