Kingston Health Sciences Centre

Centre des sciences de la santé de Kingston

Hôpital Hotel Dieu Hospital

KGH Hôpital Général de Kingston General Hospital

Visit: ______________________

CR: ______________________

Name: ______________________

Date of Birth: ______________________

E-VISIT DOCUMENTATION RECORD

Attending/Physician Service: ____________________

Date and Time of E-Visit ____________________ (yyyy/mm/dd) (hhmm)

Name of Caller ______________________________

Address of Caller ______________________________

Telephone Number of Caller ______________________________

☐ **Consent Obtained**

Reason for E-Visit

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Patient Assessment

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Analysis and Plan
(including consultation, education, and referrals)

Protocol/Guideline Used: ☐ Yes Specify ____________________ ☐ No ☐ Not applicable

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Evaluation and Follow-Up:

☐ Patient to contact family physician
☐ Patient to go to Emergency Department
☐ Clinic visit scheduled ____________________ (yyyy/mm/dd) (hhmm)
☐ Patient to call back if necessary
☐ Other ______________________________

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Printed Name	**Designation**	**Signature**	**Date** (yyyy/mm/dd)	**Time** (hhmm)

Original- Chart / Yellow – Office

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