TELEHEALTH APPOINTMENT LOG

SITE: _____ WEEK OF: _____ FILLED OUT BY: _____

APPT DATE	PATIENT NAME	GENL SPECIALTY PT SEEN FOR	DOB	MRN (if UHC site)	PROVIDER	PATIENT SITE	COUNTY PT LIVES IN	PAYER

NON-CLINICAL TELEHEALTH EQUIPMENT USAGE TRACKING LOG

USAGE DATE	TOPIC/SUBJECT	START TIME	END TIME	TYPE: Medical (CME), Admin, Educ, Committee, Other	OTHER SITES ATTENDING

* AT END OF WEEK return form to MO Telehealth Network, cashs@health.missouri.edu or fax 573-882-5666

If you have any questions, please contact MTN 573-884-7958