Missouri Rehabilitation Center
University of Missouri Health Care

Tele-Health Communication Form

Patient Name: ______________________________ Patient Phone Number: ________________________
Patient's DOB:______________________________ Social Security Number: _______________________
Patients Address: ____

Type of Clinic Visit: Orthopedic Dermatology

Date and Time of Set-up Tele-Health Visit: ____

Contact person at your office: ____

Purpose of the follow up visit: ____
____
____

Prior to the scheduled visit

Labs to be ordered (we need scripts with diagnosis) ____
____

X-ray's to be ordered (we need scripts with diagnosis) ____
____

Nursing Duties to be performed for the Tele-Health Visit

- ☐ Vital Signs
- ☐ Weight
- ☐ Dressing change (please write orders for the dressing change)
- ☐ Suture Removal
- ☐ Staple Removal
- ☐ Other ____

____
____

Please fax this form and all orders to 417-461-5733
Please call 417-461-5365 or 417-461-5367 if you need to talk to Terri or Gail about the TeleHealth Visit.

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