West Park HEALTHCARE CENTRE get your life back

VIRTUAL VISIT CONSENT

LABEL

West Park Healthcare Centre (Centre) is now offering virtual visits as part of your rehabilitation services. This means that your care team will provide services (i.e. therapy) using the telephone, email, or through video-conference. Video-conferencing can be done on a computer, a tablet or a smart phone.

Virtual visits at Centre will occur using a secure video-conferencing service provided by the Ontario Telemedicine Network (OTN) or another secured Centre approved platform, such as Zoom Healthcare, Team Viewer.

For us to connect with you using video-conference, we will need an email and a telephone number so we can communicate with you. Your care team will call you if there are technical difficulties during your sessions.
All electronic communication including phone, video-conference, and email carries some risk. For information about virtual visits and how to protect your privacy when using email and the internet, please see our FAQ's at westpark.org.

- By consenting to group video/audio conference sessions, you are also consenting to the following:
  - Sharing your name
  - Sharing what you say (using device microphone)
  - Sharing what you do or show through your webcam or photo icon with all participants in the group sessions.
  - You agree that you will not record (i.e. audio, photo, or video) during group sessions. It is important to maintain confidentiality/privacy of other group members.
  - You agree not to share the names of your group members or any other information about them with anyone outside of the group.

C1368

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I hereby consent to the following:

Audio visits (i.e. telephone)		☐ Yes	☐ No
Use of email		☐ Yes	☐ No
Video-conferences *(ONLY available if consented to email use)*		☐ Yes	☐ No
Group video/audio conferences (if offered)	☐ Not applicable	☐ Yes	☐ No

Please provide the following information:

My Email: _____ My Phone Number: _____

The following individuals may join any of my telephone/video conference calls:

Name_____ **Relationship** _____

Email _____ **Phone #** _____

_____ YY/MM/DD _____

Signature of Patient or Substitute Decision Marker (SDM)

_____ YY/MM/DD _____

Signature of Witness

Check here ☐ *if consent obtained by phone*

IIf the person signing is not the patient, please print the name and state the relationship and signing authority

_____ _____ _____

Name (Please Print) Relationship to Patient Authority (i.e. Power of Attorney/SDM)

You may withdraw your consent for telephone, video-conferencing, and/or email communication at any time by contacting the clinic/unit.

Consent Obtained by:

Staff:

_____ _____

Print Name Signature

This form must be placed in patient's chart immediately upon completion.
All email communication will be printed and placed in patient's clinical record.

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