Recommended Medical Record Standards for Telemedicine Consults

Purpose: To provide guidelines for the documentation of a telemedicine consult.

Information/Guidelines:

1. The following guidelines are recommended when participating in a consultation held via telemedicine at the patient site:
   - Create a facility outpatient record for each consult
   - Have the patient/legal representative sign the Telemedicine Consent Form prior to the consult and added to the patient’s record.
   - Documentation should include:
     - Name of consulting healthcare provider
     - Names of people present at both locations
     - Bandwidth
     - Any procedures/assessments conducted (i.e. use of exam camera, vital signs taken, etc)
     - Any pertinent patient factors
     - Verbal orders received
   - Add to medical record any patient information received in support of the consult

2. The following guidelines are recommended for consulting healthcare provider conducting a telemedicine consultation:
   - A patient record be created the same as if the patient was being seen in the consulting healthcare provider’s clinic
   - Documentation of finding using the usual format
   - Additional documentation:
     - Consult held via telemedicine and patient location
     - Names of people present at both locations and their role
     - Bandwidth
     - Include all electronic communication in regards to patient consult

3. The facility’s Medical Records policies regarding the release of patient information will apply to all telemedicine patient records.

4. Patient records created as a result of a telemedicine consult are recommended to be stored in the same fashion as any other patient record.