TORBAY PHYSIOTHERAPY & HAND THERAPY

Telehealth Consent Form

Client Details

Name:

Address:

Date of Birth:

Nominated email address:

Referring Doctor (if appropriate):

Consent Statements

- I consent to the passing of information in relation to my treatment to be sent to the nominated email address.
- I declare that the information provided on this form is true and accurate at the time of signing and that my identity is that stated on this form.
- I give permission for my therapist to contact my referring doctor in reference to my treatment.
- I give permission for my therapist to contact further specified health professionals (e.g. General practitioner, Orthopaedic specialist) in reference to my treatment.
- I understand that Telehealth treatment (treatment via email, telephone or video conference) has limitations (e.g. therapist being unable to conduct a physical examination) and that my therapist will make every effort to still provide a high standard of care.
- Should my therapist feel that a physical examination is required in order to ensure best treatment, I consent to my therapist referring me onwards for a physical examination and/or other relevant testing.

Signed: _____ (Client)

Date:_____