

	HOSPITAL SULTAN ABDUL AZIZ SHAH UNIVERSITI PUTRA MALAYSIA Kod Dokumen: HSAAS/PSY/BR87
	PATIENT INFORMATION CHECKLIST FORM

Name of client:

I/C of client :

Date :

Please ensure the following is checked before providing teleconsultation services to the client:

	Client is able to adequately use a device to access the internet and use an online video conferencing application.
	Client has agreed to use zoom/ google meet/ webex/ Microsoft team (<i>circle where applicable</i>) for the teleconsultation.
	Client is aware that steps are taken to minimize data breach and protect their confidentiality.
	Client is aware that they/the clinician can terminate teleconsultation services as long as advance notice before the next appointment is given.
	Client is aware that teleconsultation is not a full replacement for physical consultation and the client will still need to come in for physical consultation if necessary.
	Client has filled up the contingency plan for emergency contact.
	Client is aware what to do if any technical issues arise during teleconsultation.
	Client is informed of the appointment making, payment and registration process that needs to be done before the teleconsultation session.
	Client is aware that you will break confidentiality if risk of harm is present.
	Client has received the written information on the psychiatry clinic contacts and bank account information for payment.
	Client has signed the consent form.

Clinician Signature:

Name :

Date :