Virtual Visit Documentation Form

Date _____/_____/_______

Time Start _____ a.m. / p.m.

Total Time of Visit _____ min.

Patient Information

First Name __________________ Last Name _____________________________

DOB _____/_____/_______ Phone ___________________________________

Gender __________ Email ____

Mode of Communication

☐ Telephone ☐ Text ☐ Video Chat ☐ Instant Messenger ☐ Other

Diagnosis ____

Aetiology ____

Symptoms

Clinical Findings

Prescriptions Provided

Treating Provider ____

Signature ____

CPT CODE ____________________ **DATE ENTERED IN EMR** ____/_____/_____

INITIALS __________