Effingham Health System is implementing an innovative medical program, where parents may opt-in to use telemedicine to diagnose and treat their sick children, while in school. Effingham Health TELEMED will make healthcare for children more convenient and accessible, avoid delays in treatment, and enhance learning by decreasing absenteeism.

LAUNCHING FALL 2017

The Effingham Health System/Effingham County Schools Telemedicine pilot program—launching in Guyton Elementary and Springfield Elementary in October—is the first of its kind in the Greater Savannah region. Effingham Health System is honored to partner with Georgia Partnership for Telehealth, which has launched telemedicine programs in over 100 schools across the state.

TREATMENT

With the parent’s permission, assessments and diagnoses will be performed by a physician or advanced practitioner from Effingham Health System. Our exceptionally trained team will advise on medical treatment and call in any prescriptions. Parents may pre-enroll, prior to the October launch, or opt-in at any point during the school year. Contact your school nurse for more information.

TECHNOLOGY

Today’s telemedicine has evolved to include cutting-edge medical treatment and innovative technology. A blue tooth stethoscope, HD digital cameras, monitors, and a digital scope, provide a high definition picture of the patient for the physician, who communicates via live cameras and a computer. While a secure connection assures patient privacy.
School-Based Telemed Process

1. Sick student is sent to School Nurse.

2. School Nurse will determine if a Telemed appointment is needed.

3. Parent will be notified of sick child and asked permission to use Telemed.

4. School Nurse will schedule Telemed appointment for same day.

5. School Nurse or Telemed presenter will take your child’s blood pressure, pulse, and temperature.

6. Telemed provider (Physician, Nurse Practitioner, or Physician’s Assistant) will assess and diagnose your child and send appropriate prescriptions to family pharmacy.

7. School Nurse will call parent with follow-up instructions from the provider.

8. Student will be sent back to class or await parent pick-up per school policy.

9. Student’s medical insurance on file will be billed for visit. (No child will be turned away due to inability to pay)

10. A summary of your child’s Telemed visit and any patient education will be uploaded to the patient portal for the parent to review.
School-Based Teledem Frequently Asked Questions

What is School-Based Telemed?

School-Based Telemed is an innovative and established model to complement and expand existing school health services to meet the needs of children through the use of technology, i.e. interactive audio, video, or other telecommunications or electronic technology that connects the child and faculty/staff in the school to a health care provider in another location.

What is the goal of the School-Based Telemed Program?

The program’s goal is to keep children healthy, in school and ready and available to learn.

Who is eligible to access services in the School-Based Telemed program?

Students and staff at the two pilot schools, Guyton Elementary School and Springfield Elementary School, are eligible to enroll in the School-Based Telemed program.

What services will be provided by the School-Based Telemed program?

The program will provide acute care services such as checking for ear infections and sore throats. If needed the provider examining the child will write a prescription that can be sent electronically to the family’s pharmacy.

How do children enroll in the School-Based Telemed program?

Parents will need to complete an enrollment packet that will be sent home with your child on the first day of school. They will also be available on the schools website and in the school nurse’s office.

How do faculty/staff enroll in the School-Based Telemed program?

Faculty/staff will need to complete an enrollment packet that will be distributed during pre-planning. They will also be available on the schools website and in the school nurse’s office.

Is there a cost for the School-Based Teledem Program services?

Medicaid/PeachCare and Private Insurance will be billed. No child will be refused treatment due to inability to pay. Financial Assistance is available.
When will health services be available in the School-Based Telemed program?

Medical Services will be provided during the school day with the exception of school closures for pilot School-Based Telemed program, beginning on October 2, 2017 at Guyton Elementary School and Springfield Elementary School.

Does a parent have to be present for the Telemed appointment?

Parents are always welcome to attend, but it is not required for acute appointments.

What if the provider orders labs for my child?

If labs are ordered by the provider, you may take your child to the lab at Effingham Hospital, Effingham Family Medicine or any lab you prefer. Strep, Flu, and Urine Analysis may be performed at the school clinic.

Will my child still be seen by the school nurse if I do not participate in the School-Based Telemed program?

Yes. Students will be seen as previously in the school clinic. However, they will not be seen by a provider unless proper forms are completed for the School-Based Telemed program.

Who will be providing the School-Based Telemed Program?

Effingham Health System (EHS) in partnership with Effingham County Board of Education (ECBOE). EHS health care professionals in conjunction with the ECBOE school nurse will provide medical services for pilot School-Based Telemed program.

How will the School-Based Telemed program be monitored?

Monitoring of the Telemed system will be done in accordance with Georgia State guidelines/regulations and standards of practice for Telemedicine. Protocols will provide guidance on the implementation of the project and to assure compliance with State medical regulations regarding but not limited to HIPAA, FERPA, and medical practice. Confidentiality of medical records will be maintained according to electronic health records standards and regulations.

Who owns the School-Based Telemed program medical records?

Medical records will be maintained by Effingham Health System.
Homeroom Teacher: ___________________________ Grade: _______________ School: ______________________

Patient Information

Mr. /Mrs. /Ms.
Last ___________________________ First ___________________________ MI ______

Address ___________________________ City ______________ State ______ Zip Code ______________

Mailing address ______________________ City ______________ State ______ Zip Code ______________

Phone Home ___________________________ Cell ___________________________

Work ___________________________ Ext ___________________________

Date of Birth ___________________________ Male or Female Single/Married/Widowed/Divorced

Social Security No. _______________ Employed Y/N Employer _______________ Full/Part/Retired

Student? Y/N Full Time/Part Time E-mail ___________________________ (Over 18yrs of age only)

Emergency Contact

Last ___________________________ First ___________________________

Relationship ___________________________

Address ___________________________ City ______________ State ______ Zip Code ______ Date of Birth ______

Phone Home ___________________________ Cell ___________________________

Work ___________________________ Ext ___________________________

Guarantor * (Financially responsible person who is signing the attached forms)

Last ___________________________ First ___________________________ MI ______ M/F

Relation ___________________________

Phone No. ___________________________ Date of Birth ______________________ Social Security No. ___________________________

Address ___________________________ City ______________ State ______ Zip Code ______

Employer ___________________________ Full /Part Phone ___________________________

Address ___________________________ City ______________ State ______ Zip Code ______
Insurance Information

Medicare No.______________ Part A/A&B /B Medicaid No.________________________________________
Wellcare No.______________ Amerigroup No.______________ PeachState No.________________________
Primary____________________ ID No.__________________________ Group No.____________________
Policy holder________________ Date of Birth____________ Social Security No.____________________
Address____________________ City____________ State____ Phone__________________________
Secondary____________________ ID No.__________________________ Group No.____________________
Policy holder________________ Date of Birth____________ Social Security No.____________________
Address____________________ City____________ State____ Phone__________________________

Self Pay  Yes or No  if yes, please select one of the following
_____ Pay balance in full at the time of service or _____ Make a payment arrangement prior to being seen

Additional Info

Race  Black/African American  Hispanic  White
Other________________________________________

Ethnicity  Hispanic or Non-Hispanic

Pharmacy Used________________________ Location________________ Phone____________________

Have you ever received care in any of our offices in the past?  If so, which one?
________________________________________

How long ago? ___________ under what name did you receive care? _______________________________

Accident Information

Is this illness due to an accident?  Yes or No

If yes,  work or auto accident___________ date of accident___________

Place of
accident_________________________________________________________________________________

If work accident,
Employer___________________________________________________________

Contact person______________________________________ Phone _____________________________
Effingham Health System is a Tobacco Free facility. The use of any tobacco products, e cigarettes or vaping equipment is prohibited on all properties, including parking areas, owned or occupied by Effingham Health System.

Authorization and Consent for Telemedicine Treatment

I hereby voluntarily give my consent for ______________________ (“Patient”) to receive health services at the Effingham County School Based Telehealth Center. I acknowledge and agree that I am the legal guardian with all legal rights to consent on behalf of the Patient for healthcare services.

I understand that the Effingham County School Based Telehealth Center uses telehealth resources to connect Patient with a healthcare provider at Effingham Hospital or the Effingham Hospital owned medical clinics (collectively “Clinic”). I consent to any physician or physician-designated health professional working on behalf of the Clinic to provide such medical tests, procedures, and treatments as are reasonably necessary or advisable for the medical evaluation and management of the Patient’s health care as determined by the healthcare provider.

I understand that the Clinic may obtain any of the Patient’s medical record information from the Patient’s doctor or primary care provider designated by me whenever necessary for treatment including referrals and/or emergency services. I further authorize release of written and verbal information pertinent to the Patient’s health care from the Effingham County School staff to the physician, school nurse, counselor and administrators whenever necessary for my care.

I understand that the use of the telehealth services are being provided for my convenience and to ensure access to healthcare services at the Effingham School Based Telehealth Center. I understand that as an alternative to consenting to the use of telemedicine services, I could see another provider at his or her office. The benefits of the telemedicine visit are to provide timely access to a healthcare professional at a lower cost. The risks of using telemedicine links is the limitation on the physical assessment of the Patient to the extent additional facts may be obtained through an in-person visit. I understand the risks, benefits and alternatives discussed in this consent and I understand that I may ask any questions regarding the use of telemedicine and any additional risks, benefits and alternatives by contacting the school nurse where Patient is enrolled.

I understand and authorize Effingham County School system to release information for payment for the delivery of healthcare services to third party payers such as Medicaid or other insurers for the purposes of billing and payment for the healthcare services rendered unless I pay for the visit in full at the time of the healthcare visit. Medicaid and other insurers will be billed for services rendered.

I understand that my signing this consent allows the physicians and professionals at Effingham County School Based Telehealth Centers to provide comprehensive health services. I also understand that I have the right to withdraw this consent at any time upon written notice to the school nurse.

I have read and understand the above information and consent to the treatment at The Effingham County School Based Telehealth Centers by the Clinic providers. I also understand that I may obtain further information regarding the health services offered by the clinic by contacting the school nurse at the school where my child is enrolled.

__________________________  ______________________  __________________________
Date/Time  Signature  Patient’s Printed Name

__________________________
Relationship: Witness:

(Must be signed by Patient or Relative when photograph(s) are obtained)

FC July 2017
Effingham Health System is a Tobacco Free facility. The use of any tobacco products, e cigarettes or vaping equipment is prohibited on all properties, including parking areas, owned or occupied by Effingham Health System.

**Release of Information**

Initial: I hereby authorize payment of the hospital benefits otherwise payable to me and applicable only to unpaid charges, for this visit directly to this office. I give my permission of this office to release medical information for insurance purposes.

**Patient Responsibility**

Initial: I understand that Effingham Physician Practices will file my insurance as a courtesy, but it is my responsibility to understand my insurance coverage. I understand that I will be responsible for any charges my insurance will not cover.

**Consent to be photographed**

Initial: I understand that photographs or other images may be recorded to document my care, and I consent to this. Effingham Health System will retain the ownership rights to these images. Images will be stored in a secure manner in my medical record. Images that identify me may be used at Effingham Health System only for purposes of treatment, payment or healthcare operations and will not be released and/or used outside the organization for any purpose unless authorized by me or my legal representative.

**Prescription (Rx) History Consent**

Initial: I authorize Effingham Physician Practices to access my prescription history in order to perform accurate medication reconciliation.

**Patient’s Rights And Responsibilities**

I acknowledge that I have been offered a copy of the PATIENT’S RIGHTS AND RESPONSIBILITIES, which details my rights as a patient at Effingham Health System (EHS).

Effingham Health System is committed to providing and supporting healthcare excellence to the citizens we serve. Our commitment to patients is reflected in our willingness to provide patient care and services and not be influenced by age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, gender identity or expression. Any person who needs emergency treatment at our facility will be treated in accordance with the Emergency Medical Treatment and Labor Act (EMTALA) and be discharged and referred without discrimination.”

Let it be known that in any instance Effingham Health System is mentioned, all departments and locations of the Health System are included.

Date/Time ___________________________ Signature ___________________________ Patient’s Printed Name ___________________________

Relationship: ___________________________ Witness: ___________________________

(Must be signed by Patient or Relative when photograph(s) are obtained)
Patient Name: ________________________________  Date of Birth: __________

**Medical History** – Have you ever had any of the following conditions or diagnoses? Check all that apply.

- **Allergies**
  - O Yes
  - O No
- **Anemia**
  - O Yes
  - O No
- **Anxiety**
  - O Yes
  - O No
- **Arthritis**
  - O Yes
  - O No
- **Asthma**
  - O Yes
  - O No
- **Depression**
  - O Yes
  - O No
- **Diabetes**
  - O Type 1
  - O Type 2
  - O Gestational
- **GERD**
  - O Yes
  - O No
- **Heart Disease**
  - O Yes
  - O No
- **Hypercholesterolemia**
  - O Yes
  - O No
- **Hypertension**
  - O Yes
  - O No
- **Seizures**
  - O Yes
  - O No
- **Stroke**
  - O Yes
  - O No
- **Other:** ____________________________________________

**Surgical History** - Have you ever had any of the following surgeries? Check all that apply.

- **Appendectomy**
  - O Yes
  - O No
- **Cholecystectomy**
  - O Yes
  - O No
- **Eye surgery**
  - O Yes
  - O No
- **Fracture repair**
  - O Yes
  - O No
- **Heart Bypass Surgery**
  - O Yes
  - O No
- **Heart stent**
  - O Yes
  - O No
- **Heart Valve Repair**
  - O Yes
  - O No
- **Hernia Repair**
  - O Yes
  - O No
- **Tonsillectomy**
  - O Yes
  - O No
- **Other:** ____________________________________________

**Medications**

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<tr>
<th>Medication Name (include all prescriptions, over the counter, and vitamins)</th>
<th>Dose</th>
<th>Frequency</th>
<th>For what?</th>
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FC 6/2017
Family History

Has your mother had any of the following?
- O Diabetes
- O Hypertension
- O Heart Disease
- O Stroke
- O Mental Illness
- O Cancer
- O Unknown

Has your father had any of the following?
- O Diabetes
- O Hypertension
- O Heart Disease
- O Stroke
- O Mental Illness
- O Cancer
- O Unknown

Has your siblings had any of the following?
- O Diabetes
- O Hypertension
- O Heart Disease
- O Stroke
- O Mental Illness
- O Cancer
- O Unknown

Has your maternal grandfather had any of the following?
- O Diabetes
- O Hypertension
- O Heart Disease
- O Stroke
- O Mental Illness
- O Cancer
- O Unknown

Has your maternal grandmother had any of the following?
- O Diabetes
- O Hypertension
- O Heart Disease
- O Stroke
- O Mental Illness
- O Cancer
- O Unknown

Has your paternal grandfather had any of the following?
- O Diabetes
- O Hypertension
- O Heart Disease
- O Stroke
- O Mental Illness
- O Cancer
- O Unknown

Has your paternal grandmother had any of the following?
- O Diabetes
- O Hypertension
- O Heart Disease
- O Stroke
- O Mental Illness
- O Cancer
- O Unknown

Other family history: ____________________________

Depression Screening – For patients 12 years old and older.

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things?
- O Not at all
- O Several days
- O More than half the days
- O Nearly every day

Feeling down, depressed, or hopeless?
- O Not at all
- O Several days
- O More than half the days
- O Nearly every day

Trouble falling or staying asleep, or sleeping too much?
- O Not at all
- O Several days
- O More than half the days
- O Nearly every day

Feeling tired or having little energy?
- O Not at all
- O Several days
- O More than half the days
- O Nearly every day

Poor appetite or overeating?
- O Not at all
- O Several days
- O More than half the days
- O Nearly every day

Feeling bad about yourself or that you are a failure or have let yourself or your family down?
- O Not at all
- O Several days
- O More than half the days
- O Nearly every day

Trouble concentrating on things, such as reading the newspaper or watching television?
- O Not at all
- O Several days
- O More than half the days
- O Nearly every day

Moving or speaking so slowly that other people could have noticed. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual?
- O Not at all
- O Several days
- O More than half the days
- O Nearly every day

Thoughts that you would be better off dead or of hurting yourself in some way?
- O Not at all
- O Several days
- O More than half the days
- O Nearly every day
Tobacco Use – For patients 18 years old and older.
Are you a smoker?
  O current smoker  O former smoker  O never smoker  O light tobacco smoker
  O heavy tobacco smoker
If current smoker, how often do you smoke cigarettes?
  O every day  O some days  O but not every day
If current smoker, how many cigarettes do you smoke a day?
  O 5 or less  O 6-10  O 11-20  O 21-30  O 31 or more
If current smoker, how soon after you wake up do you smoke your first cigarette?
  O within 5 min  O 6-30 min  O 31-60 min  O after 60 min
If current smoker, are you interested in quitting?
  O Ready to quit  O Thinking about quitting  O Not ready to quit  O 21-30
  O 31 or more

Alcohol Screening – For patients 18 years old and older.
Did you have a drink containing alcohol in the past year?
  O Yes  O No
How often did you have a drink containing alcohol in the past year?
  O never (0 points)  O monthly or less (1 point)  O 2 to 4 times a month (2 points)
  O 2 to 3 times a week (3 points)  O 4 or more times a week (4 points)
  O 6 or more times a week (4 points)
How many drinks did you have on a typical day when you were drinking in the past year?
  O 1 or 2 drinks (0 points)  O 1 to 2 drinks (0 points)  O 3 or 4 drinks (1 point)
  O 5 or 6 drinks (2 points)  O 7 to 9 drinks (3 points)  O 10 or more drinks (4 points)
How often did you have 6 or more drinks on an occasion in the past year?
  O never (0 points)  O monthly (2 points)  O less than monthly (1 point)
  O weekly (3 points)  O daily or almost daily (4 points)
Interpretation  O Positive  O Negative
(The alcohol screening is scored on a scale of 0-12 (scores of 0 reflect no alcohol use). In men, a score of 4 or more is considered positive. In women, a score of 3 or more is considered positive.)
PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rules give individuals the right to request a restriction on uses and disclosures of protected health information. Protected Health Information (PHI) is the use or disclosure about your medical treatment, payment or healthcare operations.

PLEASE PRINT BELOW THE PERSON(S) TO WHOM WE MAY DISCUSS YOUR PHI AND RELEASE INFORMATION TO:

1. __________________________________________________________
2. __________________________________________________________
3. __________________________________________________________
4. __________________________________________________________

I wish to be contacted in the following manner (check all that apply)

____ Home Telephone __________________________

____ Cell Phone Number __________________________

____ Email_____________________________________

____ Mail_____________________________________

You may leave a message with, discuss my treatment, appointments, release information, or other scheduling that may occur or give information as necessary with the above family, friend or personal representatives. I understand that Effingham Health System will refuse to discuss my information with anyone not listed above, except in an emergency. I also understand that this consent does not apply to medical providers for continuity of care.

__________________________________  ______________________________ ________________
Patient’s Signature and Date  Patient’s Printed Name  Date of Birth