

REACH COVER SHEET

CDD-UNM

Remote Site: _____ Date: _____ / _____ / _____

Referrer's Name: _____ IATV VP IP

Name of Conference and/or Consultant: _____

Reason for Televisit: _____

Primary Service Provided: _____ Name of Consultant: _____

Is this service available in your community? Yes No Supervision: Yes No

Provider Participants: _____ Family Participants: _____

1. Duration of the connection: _____ minutes.

2. Specialists who participated in the Teleconference (mark all that apply):

Number	Type	Number	Type
_____	Speech Language Pathologist	_____	Case Manager
_____	Occupational Therapist	_____	Social Worker
_____	Physical Therapist	_____	Medical Doctor
_____	Psychologist	_____	Reg. Nurse
_____	Developmental Specialist	_____	Administration Personnel
_____	Service Coordinator	_____	Other: _____

3. Location of teleconference connection:

Clinic Client's Home Hospital School Setting EI Agency

4. Was the client present at the teleconference? Yes No

5. Focus of teleconference (check all that apply):

Client care Consultation Education or Training Mentoring Clinical Supervision
Administrative

For Home Visits:

6. If teleconferencing were not available, would you have made this visit to the client's location? Yes No

7. Roundtrip to client's home miles _____

8. Estimated roundtrip drive time to this Client's home _____ minutes.

Please complete the following questionnaires for each teleconference:

1. Pre-conference Survey
2. Post-conference Survey

Center Use Only

REACH # _____

1. Client travel hub to originating site in miles _____
2. Would visit occur with out Telehealth? Yes No
3. Estimated Provider travel time saved _____
4. Name of Telehealth provider _____