Centre intégré
de santé
et de services sociaux
de la Montérégie-Ouest
Québec

MOCLI60067A

Dossier : _____

Nom, prénom : _____

Date de naissance : _____ ☐ F ☐ M
aaaa/mm/jj

NAM : _____ Exp. _____
aaaa/mm

Nom, prénom de la mère : _____

Installation : _____

VIRTUAL CARE CONSENT

Care path: _____

Virtual care is the delivery of health and social services at a distance using technology. They can involve virtual visit solutions, remote monitoring systems and technologies, and other IT solutions.

I, the undersigned, hereby _____
confirm that I have received the necessary information to sign this form attesting to my consent to virtual care.

In order for them to diagnose or perform the required follow-up remotely:
I understand that my treating physician or healthcare professional may receive or transmit the following required medical information electronically:

☐ Photos and videos ☐ Pre-/Post-visit questionnaires
☐ Surveys ☐ Others: _____

I understand that my tracking may also involve the use of one of the following connected **devices**:

☐ Blood pressure monitor ☐ Thermometer ☐ Glucometer
☐ Digital stethoscope ☐ Pulse oximeter (saturation monitor)
☐ Smartwatch ☐ Spirometer ☐ Scale (for weight)
☐ Multi-modal sensor (fall detector, location system, etc.)
☐ Other: _____

I understand that in certain cases, a copy of the virtual care report may be sent to another professional who is or will be involved in my care team.

I understand that in some cases, following virtual care, the physician or healthcare professional may deem it necessary to conduct an in-person examination. In such cases, I will be given the opportunity to decide whether or not to accept the offer of an appointment.

I understand that every effort will be made to ensure the security of images and medical information during electronic transmission and digital storage on servers located in Quebec. There are certain risks associated with the electronic transmission of information, such as breaches of confidentiality or the possibility of data loss, which I accept.

I understand that my information will be kept confidential and that only the following people will have access to it:

- The physician(s) or healthcare professional(s) designated by the virtual service.
- The treating physician or healthcare professional I consulted today.
- Any other professional whom I authorize in writing to have access.
- Authorized administrative staff and other specialists in the event of a need for medical advice or counsel.

I also agree that the information obtained during this virtual service will be used in a confidential manner for the purpose of evaluating the service and improving its quality. I understand that the information will not be used for any other purpose or disclosed to third parties.

Nom, prénom : #Dossier :

DURATION OF CONSENT

This consent is valid for the entire duration of my care period and services from the date I sign this form. I understand that this consent may be withdrawn verbally or in writing at any time by contacting the caregiver or professional who makes sure I receive the care I require.

OBTAINING CONSENT

- I consent to the use of virtual care as a means of receiving care and services required by my health condition.
- I confirm that I have understood and received the necessary explanations about virtual care.

☐ In the user's presence

User or Authorized Person signature: _____ Date: yyyy/mm/dd

Speaker or Professional signature: _____ Date: yyyy/mm/dd

☐ Remotely, verbally

As a professional or caregiver, I confirm that I have obtained verbal consent from the user before using virtual care as a means of receiving care and services.

Speaker or Professional signature: _____ Date: yyyy/mm/dd

WITHDRAWAL OF CONSENT

- I hereby revoke my consent to the use of virtual care as a means of receiving my care and services.
- I understand that I will receive my care and services according to other terms agreed upon between me and my caregivers or professionals. These terms are as follows:

_____

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_____

☐ In the user's presence

User or Authorized Person signature: _____ Date: yyyy/mm/dd

Speaker or Professional signature: _____ Date: yyyy/mm/dd

☐ Remotely, verbally

As a professional or practitioner, I confirm that I have been verbally informed by the user of their desire to revoke consent for the use of virtual care as a means of receiving care and services.

Speaker or Professional signature: _____ Date: yyyy/mm/dd