Provincial Health Services Authority
Province-wide solutions. Better health.

Vancouver Coastal Health
Promoting wellness. Ensuring care.

Providence Health Care
How you want to be treated.

VIDEO CONFERENCE REQUEST FORM

Please complete this form and submit it to the Telehealth office for processing.

Requestor Information

Name:	Telephone:
Email:	Department/Organization:
Event Title:	Conference ID number: *(If applicable)*

Event Type: *(Clinical/Clinical with Patient/Education/Administrative)*

Clinical

If you are requesting a clinical event with a patient, the Telehealth office will call you to collect the following information to complete the booking: patient first and last name, date of birth, PHN, and gender. Please do not send this information by email

Date: *(ex: Jul 21 2013)*	Pre-test Time: *(indicate time zone)*	Start Time: *(indicate time zone)*	End Time: *(indicate time zone)*

Host Site:	Alias/IP/ISDN Address:
Site booked?: ☐ Yes ☐ No	Number of Participants:

Participating Sites *(Please use the Additional Information box below if you need to add more sites.)*

Site/Community/Facility	Room #	Alias/IP/ISDN	Site Booked	Contact
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	

☐ Yes ☐ No **Separate Audio Line Required**

Additional Information

Please use this space to identify additional sites, special requirements, or if you would like to request recording of the session.

48 hours notice is required for all revisions, additions and/or cancellations
Please refer to video conference as titled on this confirmation form when requesting cancellation
Failure to comply with this request may result in your site not being connected to the video conference

SUBMIT