Bridges and Pathways Counseling Services
Twin Cities

Telemedicine Assessment for Client Fit for Services

Treating Clinician: _____ Date: _____

Client Name; _____ Client Birth Date:_____

Level of Risk:

- Have you been suicidal in the past 6 months, or are you at significant risk of becoming so? Yes ☐ No☐
- Have you been homicidal in the past 6 months or are you at significant risk of becoming so? Yes ☐ No☐
- Do you have delusions about technology/electronics, or have a significant risk of developing them? Yes ☐ No☐
- Are you willing to identify an appropriate support person who can be available during your sessions? Yes ☐ No☐
- Are you willing to provide your own location, phone number, and proof of your identity? Yes ☐ No☐
- Are you a victim of domestic abuse? Yes ☐ No☐

Technology:

- Do you have a computer/device with internet access and that has the capability of using a HIPAA compliant webpage? Yes ☐ No☐
- Do you have an email address and are you comfortable using email? Yes ☐ No☐
- Are you comfortable with using video conferencing as a means of receiving counseling? Yes ☐ No☐
- Do you have a place to receive counseling in a location that allows for confidentiality? I ask that you test the capability of your computer and internet

access with the video conferencing technology with either me or a friend. Are you willing to do this? Yes ☐ No☐

- I understand that my appointment time is valuable time with my therapist. I agree to be at my computer and ready for my therapist to invite me to my session within 5 minutes of my scheduled session. Yes ☐ No☐

- There is the potential for technology breakdowns and interruptions. Do you believe that the use of technology will cause you more distress than it will help you? Yes ☐ No☐

Region/Location:

- Will you be in the state of Minnesota when receiving counseling? Yes ☐ No☐

- Are emergency services accessible? Yes ☐ No☐

- Name of local Hospital/Medical Clinic: _____

- Phone Number:_____

- Name of Support Person who will be available during sessions:_____

- Phone Number:_____

- If Support person is not available, you agree to go to local ER or access Crisis Services if your therapist makes such a recommendation for your safety and well-being. Yes ☐ No☐

- Insurance (if applicable):

  • If your insurance will not cover your counseling, are you willing to pay out of pocket for your sessions? Yes ☐ No☐

Signature of Client: _____

Date:_____

FOR THERAPIST USE ONLY:

Score: A score of greater than 1, the client may not be an appropriate fit for counseling services through Telemedicine.

Per Assessment, this client is a fit for Telemedicine Services:

OK to proceed at this time. Yes ☐ No☐

This clinician is competent to address this client's needs/goals via Telemedicine Services
Yes ☐ No☐

This Client is not an appropriate fit for Telemedicine Services at this time.

Refer client to face to face counseling. Yes ☐ No☐

_____
Signature of Therapist

_____
Date