SWEDISH MEDICAL CENTER

Telestroke Form

Name of contracted site requesting consultation: _____

Date of request: _____ **Time of request:** _____

Contracted facilities must complete and fax this form, along with the requested documents listed below, prior to receiving Acute Telestroke service from Swedish Medical Center

Fax Instructions

Please print clearly and provide complete, current and accurate information. Fax this completed form, along with the additional requested documents, to the following two (2) locations:

1. **Swedish Registration** (fax: 206-386-2625). Please include the following documents:
    a. Copy of the Patient Information Sheet (face sheet)
    b. Photocopy of the patient identification (ID) if available

2. **Swedish TeleHealth Office** (fax: 206-320-3153). Please include the following document:
    a. Telestroke Video Consent Form

If you have questions or problems faxing, please call:

Patient Registration, Swedish/First Hill (Phone: 206-386-2561; press “3”, and then “3” again)
Stroke/Telestroke Program Manager: Phone: 206-320-3484

Patient Legal Last Name:	Legal First Name:	Middle Initial Only:
Date of Birth:	Social Security Number:	
Address:		
Chief Medical Complaint:		
Referring Physician Name : Referring Physician Phone Number:		
Swedish Medical Center Use Only		
Patient Registration Section: **Registrar Name:** _____ **Completion Date:** _____ **Time:** _____ **MRN:** _____		