UAMS Medical Center
High-Risk Pregnancy Program

To Who It May Concern

Your primary obstetric provider has requested a consultation with the UAMS Telemedicine High-Risk Pregnancy program. Please read and fill out and sign the enclosed forms prior to your scheduled visit and return them to your doctor's office to be faxed to UAMS and placed in your medical record. For the Authorization for Release of Information form, please complete items 1-4 then include your signature and the date at the bottom of the form. This information is very important to us. We use this information for quality assurance and for compiling statistical information, as well as applying for financial grants to develop studies to help future expectant mothers.

Please be assured that your information and that of your baby will only be used and disclosed in accordance with the HIPAA Privacy Rules and UAMS Privacy Policies. If you have any questions, your counselors will be glad to answer them for you.

Keeping this appointment is very important. We hope that telemedicine will save you some travel time and inconvenience. Your input is valuable and helps us improve access and quality of healthcare. **When your session is finished, please fill out the *Telemedicine Patient Post-Session Evaluation Form* in your packet. Please take a photo with your smartphone and text this information to 501-773-0787.**

If you have any questions, please feel free to call us toll free at 1-866-273-3835.

Thank you for your cooperation and assistance!

UAMS Medical Center
High-Risk Pregnancy Program

High-Risk Pregnancy Program
Telemedicine Clinic
1.866.273.3835 (toll free)

Your telemedicine appointment is scheduled.

It is important that you return your completed forms to your doctor's office to be faxed to UAMS and placed in your medical records.

If you are diabetic, please Bring Blood Sugar Logs to Every Clinic Appointment.

Video Visit Instructions

Please check your smartphone for your text appointment link 30 minutes early for your appointment.

Your provider will send a text message to your smartphone containing a link within 30 minutes of your scheduled appointment time.

1. Click the link to start your visit.
2. Wait for your provider to join the video visit – it may take several minutes for the provider to join. Please wait patiently and your provider will join your call within the allotted appointment time range.
3. If you receive the text prior to your appointment time, you may be seen if you are available. If you do not click the link in the text message, your provider will call you to help you join the video visit.

If you do not receive a text or call within 30 minutes of your scheduled time, please contact the clinic directly at 501-296-1800.

Ultrasound Visit Instructions

Please arrive 30 minutes early for your appointment.

You will go to the designated clinic or hospital for your appointment and check in at the registration desk.

1. The staff will take you to an exam room to start your visit.
2. A sonographer will be in the exam room and in some cases your primary provider may be in the room also.
3. The number of family members allowed to be with you will depend on the clinic or hospital where your visit is taking place. (that number may be zero or one, please check before your visit.)

If you are diabetic: Please Bring Blood Sugar Logs to Every Clinic Appointment.

It is important that you return your completed forms to your doctor's office to be faxed to UAMS and placed in your medical records.

High-Risk Pregnancy Telemedicine Program

What to expect:

A lot like usual doctor appointments, you may go into a patient exam room or your appointment may be in a private area of your choice. If your appointment is in your home or another private location of your choice, you will receive a text message to your smartphone with a link to click on and start your appointment (*see instructions for video visit on the previous page*).

If your appointment is in a clinic, hospital or doctor's office, you will be in an exam room. A physician, nurse and/or sonographer may also be in the exam room and you will see a piece of equipment like a television screen or computer monitor with a camera. You will receive the same kind of exams that you would receive during a usual doctor's appointment.

Health care professionals at UAMS will introduce themselves and identify you as their patient. You will be able to see and hear them, and they will be able to see and hear you. You may move and talk naturally. If you have an ultrasound, you, the health care providers in the exam room and the professionals at UAMS will be able to look at and discuss the ultrasound with you. You will be part of the discussion, so the UAMS providers may ask you questions. Do not hesitate to ask any questions.

The basic difference with a telemedicine appointment is that you will be talking with a physician or healthcare professional who is not in the same room with you. Although they are actually at UAMS, the telecommunication equipment and smartphones allow you to see, hear and communicate with the healthcare providers at UAMS almost like they were standing next to you. If you have any questions, please feel free to call us toll free at 1-866-273-3835.

UAMS
Medical Center

High-Risk Pregnancy Telemedicine Program

What is the High-Risk Pregnancy Telemedicine Program?

The High-Risk Pregnancy Program intends to improve neonatal outcomes through evidence-based care and guidelines, research, health care education and a 24/7 call center. This program offers consultations by UAMS board certified Maternal Fetal Medicine (MFM) physicians using telemedicine technology. The High-Risk Pregnancy Program is a joint program of the University of Arkansas for Medical Sciences (UAMS) College of Medicine, the Arkansas Department of Human Services, and the Arkansas Medical Society. This unique program is designed to be a support network for high-risk obstetric patients and practitioners in Arkansas. To learn more about this program, visit https://angels.uams.edu

What is telemedicine?

Telemedicine includes a variety of methods for healthcare delivery such as two-way video, email, text, wireless phones, iPads, and computers. Telemedicine can be used in clinics, hospitals and homes.

What are the benefits and limits of UAMS telemedicine?

UAMS has the only virtual team of board certified maternal fetal medicine specialists and obstetric generalists in Arkansas who team with a nurse practitioner, diabetic educator and genetic counselor to provide comprehensive care for high-risk obstetric patients. This method of healthcare delivery creates access to patients and community-based providers across the state, saving transportation cost and time. In addition, community-based providers receive valued support when needed. However, telemedicine does have limits. Some conditions are best assessed in the clinic in Little Rock.

What about consent and privacy?

The High-Risk Pregnancy Program is dedicated to protecting patient rights and privacy. You will be asked to sign a consent giving your permission to be seen via telemedicine. When you sign this consent, you are agreeing to the electronic transfer of your Protected Health Information (PHI) as well as the limits outlined. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the establishment of standards to protect patient privacy and confidentiality. The telemedicine equipment encrypts data for security; however there is a very small possibility that the data could be intercepted by unauthorized persons.

What conditions are seen over telemedicine?

Many different conditions can be evaluated through a telemedicine consult. Some of the conditions that we can evaluate include advanced maternal age, diabetes management, maternal exposures, maternal diseases, elevated maternal serum screen, family history of chromosomal abnormalities, suspected fetal anomalies detected during a level I ultrasound, oligohydramnios, polyhydramnios, fetal arrhythmias, and intrauterine abnormalities**.**

What about reimbursement?

Insurance coverage for Telemedicine services should be similar to in person consults under the Arkansas Telemedicine Law: Arkansas Act 887.

What if I have questions?

PLEASE ASK ANY QUESTIONS YOU MAY HAVE. There are no dumb questions. Our staff welcomes questions. You may ask the telemedicine nurse, genetic counselor or physician questions at any time during your clinic visit. If you need information about appointments, insurance, your rights or anything else, please call **1.866.273.3835** (toll free).

(Place MR Label Here)
MR#:
Patient's Name:
Patient's Address:

UAMS
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Authorization for Release of Information TO UAMS

Arkansas Reproductive Genetics Program

I hereby authorize the Hospital where I deliver my baby and my Obstetrician to release medical information on the **patient (mother) and baby** of patient to:

UAMS Medical Center, Arkansas Reproductive Genetics Program, 4301 West Markham, Mail Slot 506, AR 72205, Phone (501) 296-1700, Fax (501) 296-1701.

1. **Estimated date of delivery:** _____
2. **Name of Hospital** where _____
   I plan to deliver my baby **(if known)**
   Address _____
   Street Address *City* *State* *Zip*
3. **Name of My Obstetrician:** _____
4. **Name of patient/mother** _____
   Medical Record # of mother (if known)_____ of baby (if known) _____
   Mother's Date of Birth +/or Social Security #: _____
   Phone #: _____
5. Information requested to be released
   - _X_ Delivery room report
   - _X_ Operative Report
   - _X_ Discharge-Summary
   - ___ Baby's History & Physical
   - ___ Other _____
   - _X_ Baby's Admission Record
   - _X_ Baby's Discharge Summary
   - _X_ Autopsy report
6. Purpose of release is at the request of the patient or: ____ Insurance or Other Payment
   ____ Medical Care ____ Other (explain): _____
7. This Authorization will expire 18 months from the date I signed this Authorization. I understand that I am not required to sign this Authorization, and that I may revoke this Authorization at any time by giving written notice to the Hospital where my baby is delivered. A revocation of this Authorization will not apply to records already released in reliance upon the Authorization. A photocopy of this signed Authorization shall constitute a valid Authorization.
8. I understand that once the above information is disclosed, it may be re-disclosed by the party receiving the information, and the information may no longer be protected by Federal privacy laws and regulations. However, information disclosed to UAMS is protected by Federal privacy laws and regulations.
9. Treatment, payment, and enrollment or eligibility for benefits will not be conditioned on your signing this Authorization.

Signature of Patient/ Legal Representative _____ **Date/Time:** _____

If Legal Representative signs for Patient (mother), state relationship: _____ **Date:** _____
(such as parent of a minor, court-appointed guardian, administrator of estate of deceased, attorney-in-fact appointed with power of attorney, or health care proxy)

NOTE TO STAFF: Provide Copy of Signed Authorization to Patient/Legal Representative

(Place MR Label Here)
MR#:
Patient's Name:
Patient's Date of Birth:

UAMS Medical Center

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High-Risk Pregnancy Program

INSURANCE

It is your responsibility to work with your physician and insurance carrier to meet the requirements of your policy. Failure to do so may result in a denial/reduction of insurance coverage. If your insurance carrier is Tricare/Humana, QualChoice, Prudential, BCBS or any HMO, you may need a referral from your primary care physician for your visit with UAMS. You will be expected to make a payment for any co-payment/deductible required by your particular plan. A referral from your primary care physician does not waive the necessity of these payments.

If you have Arkansas Medicaid, please include your number with your paperwork.

If you are a self-pay Health Department referral and met qualifications for the "Women's Health referral/payment agreement for perinatal health services, it is your responsibility to provide this paperwork at the time of your visit". Failure to do so may result in you being responsible for payment. Contact your local health unit with any questions regarding this form. If you have questions regarding your bill or insurance, please call to speak with the insurance coordinator; their number is 501-686-7400.

(Place MR Label Here)
MR#:
Patient's Name:
Patient's Date of Birth:

UAMS Medical Center

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Please remember to include a copy of *both* the front and the back of your insurance card!

Insurance Card FRONT	Insurance Card BACK

**Note: If we do not receive this information, the patient account will be the responsibility of the guarantor.*

UAMS
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Authorization and Consent for Third Party Patient Account Responsibility

To Be Completed By Patient:

I hereby authorize and give consent for billing statements of my treatment by UAMS to be mailed to the person named below, at the address indicated below. I understand that the billing statement includes a description of services provided. I further understand that this person will accept full responsibility as the Guarantor of my patient account to pay any balance remaining after insurance has paid.

Name of Designated Account Guarantor (Please Print)

Address to which account statements are to be mailed (Please Print)

City State Zip Code

Signature of Patient or Guardian Date Time

To Be Completed by Designated Account Guarantor, if the Patient is not the Guarantor:

I agree to accept full financial responsibility for charges incurred by the above named patient for services rendered by UAMS. I agree to pay such charges or any balance remaining after the patient's insurance has paid.

Signature of Account Guarantor Date Time

(Place MR Label Here)
MR#:
Patient's Name:
Patient's Date of Birth:

UAMS Medical Center

Authorization & Consent to Videoconference(s) with the UAMS Telemedicine Clinic

Patient's Name: _____

Consent is good for videoconferences to end _____ , 20____

I understand that my image and my Protected Health Information will be transmitted electronically through the videoconference(s) to physicians, healthcare professionals and to other UAMS personnel.
I understand that the individuals receiving my information are authorized to receive the information.
I understand that the information received is for the purpose of providing medical diagnostic assessment and treatment services to me.
I understand that the risk of unauthorized persons intercepting the transmission is extremely small.
I understand videotapes may be recorded and used to assist with my identification, diagnosis and treatment, and the payment of my bill. These images may also be used for UAMS Health Care Operations such as performance improvement and educational purposes within UAMS. Other than for treatment, payment and health care operations, images that identify me will be released outside UAMS only upon written authorization from me or my legal representative.

I understand that I may withdraw my permission at any time prior to the videoconference or during the videoconference(s).
I understand that no action will be taken against me for withdrawing my permission.
I understand that if I interrupt the videoconference, it will be incomplete and cannot be used to provide treatment or services for my current condition.
I understand that I may still get a consultation with a doctor or other healthcare professional.

I understand that there are limits to Telemedicine technology, therefore, there is no guarantee that this Telemedicine session will get rid of the need for me to see a doctor in person in order to receive appropriate or additional treatment for my current condition.

I have received and read the High-Risk Pregnancy Telemedicine information sheet.
I have read this Authorization.
I have had the opportunity to ask questions and am satisfied with the answers.

I give my consent to participate in the UAMS High Risk Pregnancy Telemedicine videoconference(s).

_____ _____ _____
Patient/Legal Representative Signature Date Time

_____
Printed Name of Patient/Legal Representative

_____ _____ _____
Witness Signature Date Time

(Place MR Label Here)
MR#:
Patient's Name:
Patient's Date of Birth:

UAMS Medical Center

UAMS Medical Center
High-Risk Pregnancy Program
Patient Information

If you need any help completing this form, your genetic counselor or APN can assist you!

Full Name: _____

Address: _____

Name of Baby's Father: _____

	You	Father of the Baby
Phone #		
Birthdate		
Social Security #		
Education Completed		
Occupation		
Ethnicity		

MEDICAL AND PREGNANCY INFORMATION

Have you experienced any pain or bleeding during this pregnancy? If so, please explain: _____

_____

Please list any allergies: _____

Please list any medications you have taken during this pregnancy: _____

_____

Total number of pregnancies: _____

Date of last menstrual period: _____

Estimated due date: _____

Who is the healthcare provider/doctor taking care of you in this pregnancy?

_____

PREGNANCY INFORMATION

Year	Gestational age at time of delivery	Mode of delivery (vaginal/c-section)	Gender	Complications (e.g. gestational diabetes, preeclampsia, miscarriage)

(Place MR Label Here)
MR#:
Patient's Name:
Patient's Date of Birth:

UAMS Medical Center

YOUR MEDICAL HISTORY

Please list any chronic conditions (e.g. hypertension, diabetes, seizure disorder, hyperthyroid, lupus) and age of diagnosis: _____

_____

_____

Surgical history: _____

_____

Tobacco use?	□ Yes	How Much? _____	□ No	□ Former
Alcohol use?	□ Yes	How Much? _____	□ No	□ Former
Drug use?	□ Yes	How Much? _____	□ No	□ Former

FAMILY HISTORY

You	Father of the Baby
How many children do you have together? Sons: _____ Daughters: _____ Do they have any health concerns?	
How many siblings do you have? Sisters: _____ Half-Sisters: _____ Brothers: _____ Half-Brothers: _____ Do they have any health concerns? Do their children have any health concerns?	How many siblings does he have? Sisters: _____ Half-Sisters: _____ Brothers: _____ Half-Brothers: _____ Do they have any health concerns? Do their children have any health concerns?
Do your parents have any health concerns?	Do his parents have any health concerns?
Do your aunts, uncles, grandparents, or cousins have any health concerns?	Do his aunts, uncles, grandparents, or cousins have any health concerns?
How many children do you have from a previous relationship? Sons: _____ Daughters: _____ Do they have any health concerns?	How many children does he have from a previous relationship? Sons: _____ Daughters: _____ Do they have any health concerns?

Signature: _____ Date: _____ Time: _____