Virtual Emergency Triage

Welcome to the XXXXXXXXXXXX virtual triage

Please note, if this is a life-threatening emergency please dial triple 000 and request an urgent ambulance.

Responses to items in this form are to represent details of the patient who will be seeing the Doctor.

Our virtual triage is open from 1:00 pm to 9:30 pm. Out of these hours, you will need to contact your usual healthcare provider or service.

Please ensure you meet the following criteria to continue with our virtual triage process:

You have a device that will enable a telehealth consult (video and audio) Valid medicare card. By proceeding with this registration, you are providing consent for your de-identified data to be included in any analysis looking at outcomes of this virtual triage system. It is anticipated that the results of this project may be published and/or presented in a variety of forums. In any publication and/or presentation, information will be provided in such a way that you cannot be identified.

If you do not want your information to be used, please contact the following xxxxxx

To continue, please answer the following questions

Time __________________________________________

Do you have a device that will enable a telehealth consultation (video and audio)?

☐ Yes
☐ No

Do you have a valid medicare card?

☐ Yes
☐ No

The Northern Hospital is my current closest emergency department, or I am a Northern Health patient

☐ Yes
☐ No

Your responses indicate that you are not eligible to participate in the virtual ED, or it is outside the hours that we operate (1:00 pm to 9:30 pm).

You will not be contacted by our team.

Please contact your GP or attend your nearest Emergency department. If your condition deteriorates, please contact 000.
Registration

Date

__________________________________

Have you been a patient at XXXXXXXXXXXXXXX previously

○ Yes
○ No

First name

__________________________________

Last name

__________________________________

note: incomplete or inaccurate information will delay registration and your consultation

Middle name (initial)

__________________________________

Date of birth (D-M-Y)

__________________________________

Country of birth

○ Australia
○ New Zealand
○ Other

Please report your country of birth

__________________________________

Age

__________________________________

Sex

○ Female
○ Male
○ Other

Marital status

○ Married
○ Never married
○ Widowed
○ Divorced
○ Separated

Religion

○ No religion
○ Anglican
○ Catholic
○ Greek Orthodox
○ Macedonian Orthodox
○ Islam
○ Other

Please describe your religion

__________________________________

Do you require an interpreter?

○ Yes
○ No
| Please describe your preferred language | Arabic | Assyrian | Cantonese | Croatian | Greek | Italian | Macedonian | Mandarin | Persian | Turkish | Vietnamese |
|----------------------------------------|--------|----------|-----------|----------|-------|---------|------------|----------|---------|---------|------------|
| Other                                   |        |          |           |          |       |         |            |          |         |         |            |

Please describe your preferred language

| Home address (must be Australian)- Residential street address (e.g. 123 Smith st) |
|----------------------------------------------------------------------------------|
|                                                                                   |

| Suburb                                                                 |
|--------------------------------------------------------------------------|
|                                                                         |

| Post-code                                                                 |
|--------------------------------------------------------------------------|
|                                                                         |

| State | ACT | NSW | NT | QLD | SA | TAS | VIC | WA |
|-------|-----|-----|----|-----|----|-----|-----|----|

Current physical location

| Same address as above | Different address |
|-----------------------|-------------------|

| Current physical location- Residential street address (e.g. 123 Smith st) |
|--------------------------------------------------------------------------|
|                                                                          |

| Current physical location Suburb |
|---------------------------------|
|                                 |

| Current physical location Post-code |
|-------------------------------------|
|                                     |

| Mobile phone number |
|---------------------|
|                     |

| Email address       |
|---------------------|
|                     |

| Emergency contact name |
|------------------------|
|                        |

| Emergency contact telephone number (mobile) |
|--------------------------------------------|
|                                            |
Emergency contact relationship to patient (e.g. mother) ____________________________________

Second emergency contact name (we require two emergency contacts for children) ____________________________________

Second emergency contact telephone number (mobile) ____________________________________

Second emergency contact relationship to patient (e.g. mother) ____________________________________

Please provide your GP details:

   Name, and Clinic or address ____________________________________________

Medicare number (10 numbers) ________________________________

Medicare identification number (the number listed next to your name) ________________________________

Medicare expiration date (valid to) 6 numbers (e.g Jan 2020 = 012020) ________________

Do you hold a DVA gold card?  Yes  No

Please provide your DVA gold card number (e.g. VX 12345, or, QHS 12345) ________________________________

Is your presentation related to TAC or WorkCover  Yes  No

Do you hold a Centrelink pension or health care card  Yes  No

Please provide your Centrelink pension or health care card number ________________________________

Do you currently have private health insurance?  Yes  No

Which health fund are you with? ________________________________

Please enter your health fund membership number ________________________________

Do you identify as an Australian Aboriginal and/or Torres Strait Islander person?  No  Yes - Aboriginal  Yes - Torres Strait Islander  Both Aboriginal and Torres Strait Islander
| Question                                                                 | Answer |
|--------------------------------------------------------------------------|--------|
| **Do you have a parent or guardian present?**                            |        |
| Yes                                                                      | No     |
| **Parent or guardian first name**                                        |        |
| **Parent or guardian last name**                                         |        |
| **Parent or guardian phone number (mobile)**                             |        |
| **Parent or guardian email address**                                     |        |
| **In 2 or 3 words, can you describe your problem eg. backpain or cough?**|        |

Please click submit to complete your registration.

Upon successful submission of registration, you will be directed to the XXXXXXXXXXXXX page.
Evaluation

Dear [first_name],

Regarding: Virtual triage registration
Date of registration: [date]

We wish to evaluate your experience with the virtual triage (video-conference) consultation.

The following survey contains questions about your experience. By proceeding with this survey, you are providing consent for your data to be included in any analysis looking at outcomes of this project. It is anticipated that the results of this survey may be published and/or presented in a variety of forums. In any publication and/or presentation, information will be provided in such a way that you cannot be identified.

Please click next to proceed to the survey

Overall, based on your experience, how do you feel about the use of videoconference for the emergency department?
- Extremely positive
- Positive
- Neither positive or negative
- Negative
- Extremely negative

Compared to face to face consultations, the perceived burden required for videoconferencing is
- No burden
- Limited burden
- Extensive burden

Based on your experience, the videoconference achieved it's desired outcome
- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

I had confidence in using the videoconference system
- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

Where would you have sought treatment if the videoconference virtual emergency department was not an option?
- General Practitioner (GP)
- You would have travelled to your nearest Hospital Emergency Department
- You would not have sought any treatment
- Other

You selected 'other' above. Please describe further

When conditions return to normal following the COVID-19 pandemic, I would continue to use videoconference compared to face-to-face for emergency department consultations if able.
- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

Please provide any further comments about your experience if you wish
Dear [baseline_arm_1][first_name],

Regarding: Virtual triage registration
Date of registration: [baseline_arm_1][date]

We wish to evaluate your experience with the virtual triage (video-conference) consultation.

The following survey contains questions about your experience. By proceeding with this survey, you are providing consent for your data to be included in any analysis looking at outcomes of this project. It is anticipated that the results of this survey may be published and/or presented in a variety of forums. In any publication and/or presentation, information will be provided in such a way that you cannot be identified.

Please click next to proceed to the survey

| Question                                                                 | Options                                      |
|--------------------------------------------------------------------------|----------------------------------------------|
| Overall, based on your experience, how do you feel about the use of videoconference for the emergency department? | Extremely positive, Positive, Neither positive or negative, Negative, Extremely negative |
| Compared to face to face consultations, the perceived burden required for videoconferencing is | No burden, Limited burden, Extensive burden |
| Based on your experience, the videoconference achieved it's desired outcome | Strongly agree, Agree, Neither agree nor disagree, Disagree, Strongly disagree |
| I had confidence in using the videoconference system                     | Strongly agree, Agree, Neither agree nor disagree, Disagree, Strongly disagree |
| Where would you have sought treatment if the videoconference virtual emergency department was not an option? | General Practitioner (GP), You would have travelled to your nearest Hospital Emergency Department, You would not have sought any treatment, Other |
| You selected 'other' above. Please describe further                      |                                              |
| When conditions return to normal following the COVID-19 pandemic, I would continue to use videoconference compared to face-to-face for emergency department consultations if able. | Strongly agree, Agree, Neither agree nor disagree, Disagree, Strongly disagree |
| Please provide any further comments about your experience if you wish    |                                              |