

**Facility/Program Name**

**Name and/or Representative:**

**Date telemedicine began:          Ended:**

**Record #**

**Care Plan Date(s):**

**Comprehensive Telemedicine/Telephonic Care Plan During COVID-19 State of Emergency**

**Need/Barrier:**

<b>Date</b>	<b>Preferences</b>	<b>Strengths</b>	<b>Goal</b>	<b>Intervention</b>	<b>Resp. Dept.</b>	<b>Outcome</b>

Revised 3/24/2020