METRO
Community Health Centers

Telehealth Visit Request

Requesting Telehealth Services: (check all that apply)

Primary Care: ☐ **Psychiatry:** ☐ **Neurology:** ☐

Have you been seen at Metro Community Health Centers before? **Yes** ☐ **No** ☐

First Name:

Last Name:

Home Address: **City:** **State:** **ZIP:**

Date of Birth:

Primary Insurance: **ID Number:**

Secondary Insurance: **ID Number:**

Phone Number for Telehealth Visits:

Email Address for Telehealth Visits:

Name of Caregiver or Scheduling Contact:

Caregiver or Guardian Name:

Care Manager Name:

Care Manager Email:

Care Management Organization:

Does patient reside in group home: Yes ☐ **No** ☐

If Yes, Name of Agency:

Pharmacy:

Pharmacy Phone Number: