|  |  |  |
| --- | --- | --- |
| **To:** Dr. | | **Date:** |
| **From:** | | **Fax/Email:** |
|  | |  |
| **Re: Proactive Visits** | | |
| We would like to schedule a regular time for your proactive visits at [Facility Name]. To facilitate your attendance (by phone, virtual video link, or in person), please complete the following questionnaire regarding your availability and preferences, and return it at your earliest convenience. | | |
|  | | |
| **1** | What dates and times are you able to attend proactive visits? Due to staffing and nursing tasks, the below dates and times are preferred. However, if these absolutely do not work for your schedule, please indicate below and we will do our best to accommodate! **Indicate your preferences in rank order (1st, 2nd, 3rd, etc).** | |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **TIME PERIOD** | **MONDAY** | **TUESDAY** | **WEDNESDAY** | **THURSDAY** | **FRIDAY** | | **Morning** (9:00 – 11:30) |  |  |  |  |  | | **Early Afternoon** (13:00 – 14:30) |  |  |  |  |  | | **Other** (please specify) |  |  |  |  |  | | |
| **2** | At what frequency would you like your proactive visits scheduled? Recommended frequency **= 4 - 6 weeks / resident.** | |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **Every 2 Wks** | **Every 4 Wks** | **Every 6 Wks** | **Every 8 Wks** | **Other** | **Comments** | | ☐ | ☐ | ☐ | ☐ | ☐ |  | | |
| **3** | When would you like this visit schedule to commence? | |
| |  |  |  | | --- | --- | --- | | **ASAP** | **After Date Below** | **Comments** | | ☐ |  |  | | |
| **4** | If you have several patients at the facility, what is the maximum number you would like to visit at one session? | |
| |  |  |  | | --- | --- | --- | | **1-5 Residents** | **As Needed** | **Comments** | | ☐ | ☐ |  | | |
| **5** | What is your preferred method of communication if the visit is virtual? | |
| |  |  |  | | --- | --- | --- | | **Phone** | **Video** | **Other** (please indicate) | | ☐ | ☐ |  | | |
| **6** | We would like to have the ability to coordinate your patient visit by video link if and when required. Please provide your contact information below, so that we know how to best do this. | |
| |  |  |  | | --- | --- | --- | | **Cell #** | **Email** (for virtual meeting invite) | **Other** (please indicate) | |  |  |  | | |

*Thank you for taking the time to fill out this questionnaire!*