GREYSTAR
HEALTHCARE SERVICES LLC

REMOTE PATIENT TELEMONITORING
REFERRAL / MD ORDER FORM

PATIENT INFORMATION:

Patient Name:

Date of Birth:

Gender:
[ ] Male [ ] Female [ ] Other

Medicaid MCO / Insurance ID #:

Address:

City: State: Zip:

Phone #:

DIAGNOSIS:

Primary Diagnosis (ICD-10):

Secondary Diagnoses (ICD-10):

ORDERING PROVIDER INFORMATION:

Provider Name:

NPI #: Practice Name:

Office Phone #: Office Fax #:

MONITORING DEVICES: *(Check All That Apply)*

[ ] Blood Pressure [ ] Pulse Oximeter [ ] Digital Scale [ ] Glucometer

ALERT THRESHOLDS:

Blood Pressure	SpO2	Weight Gain (24hr)	Blood Glucose
_____ / _____	_____ %	_____ lbs.	_____ / <_____

CLINICAL INDICATION:

[ ] Congestive Heart Failure (CHF)
[ ] COPD
[ ] Diabetes
[ ] Hypertension
[ ] Post-Hospitalization Monitoring
[ ] High-Risk Patient
[ ] Other: _____

ORDERS:

[ ] Initiate Remote Patient Telemonitoring
[ ] Device Setup & Patient Education
[ ] Daily Monitoring with Clinical Review
[ ] Notify Provider of Abnormal Readings
[ ] 180-Day Monitoring with Ongoing Evaluation

PHYSICIAN ORDERING STATEMENT:

I hereby order the services outlined in this document for the above-named patient. Based on my evaluation and review of the patient's medical condition, these services are medically necessary for the treatment and management of the patient's diagnosed condition(s).

I authorize the initiation of services as specified and direct the home health agency and/or telemonitoring provider to implement the Plan of Care. I will remain actively involved in the patient's care and will review and revise orders as clinically indicated.

Physician Signature: _____

Printed Name: _____ Date: _____

Please Include the Last Primary Physician Visit Summary.

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