fme
First Medical Equipment and service corp.

PHYSICIAN FORM HOME INR MONITORING /or supplies

PATIENT INFORMATION

Patient Name : _____ DOB: _____ Gender ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip : _____

Telephone : _____ Alternative #: _____ Insurance _____ Insurance # _____

PHYSICIAN INFORMATION

Practice Name : _____ Prescribing Physician: _____

Address: _____ City: _____ State: _____ Zip : _____

Telephone # : _____ Fax # : _____ Upin # : _____ NPI # : _____

PRESCRIPTION AND STATEMENT OF MEDICAL NECESSITY

This form serves as an order for Home INR Monitoring equipment, supplies, and related services. Equipment and supplies may be provided by FME.
I certify that it is medically necessary for the patient to self-test frequently in order to maintain a stable INR,
optimize its therapeutic effects and avoid the complications identified on warfarin's product labeling. I further certify that the patient's medical record contains supporting documentation to substantiate this medical need. I certify that this patient will undergo a training program which may include the Face to Face training protocols and Patient Outreach Support to ensure that he/she is capable of self-testing. The patient or their caregiver has no condition that makes self-testing unsafe (e.g. cognitive disorders). I agree to notify FME if the patient or their caregiver develops a condition that makes self-testing unsafe.

PATIENTS'S DIAGNOSIS	ICD-9-CM Code	ICD-10-CM Code	Circumstances and Complications:	Comorbidities
☐ Mechanical Heart Valve	V43.3	Z95.2	☐ Long Term Anticoagulant Use	☐ Diabetes
☐ Valve Mitral	424.0	I34.0 - I34.8	☐ History of Unstable INR	☐ Congestive Heart Failure
☐ Valve Aortic	424.1	I35.0 - I35.9		
☐ Atrial Fibrillation	427.31	I48.0 - I48.92	☐ History of Major Bleeding	☐ COPD
☐ Pulmonary Emboli	415.19	I26.01 - I26.99	☐ History TIA/Stroke	☐ Thyroid Disorder
☐ DVT (Deep Vein Thrombosis)	453.40	I82.401 - I82.4Z9	☐ Potential Drug/Dietary Interaction	☐ Hypertension
☐ Venous Embolism & Thrombosis	453.3	I82.3	☐ Venipuncture Difficulty	**Urgency**
☐ Primary Hypercoagulable State	289.81	D68.51 - D68.62	☐ Clotting Disorder/Coag. defect	☐ Expedito ☐ Standard
☐ Thrombophlebitis Nos	451.9	I80.00 - I80.9	**Warfarin (Coumadin) Start Date :** _____	
☐ Aneurysm of Pulmonary artery	417.1	I28.1 - I28.9	**MD Notes : (ICD-10)** _____	
☐ Chronic Pulmonary Heart Disease	416.8	I27.2 - I27.9	_____	
☐ Primary Pulmonary Hypertension	416.0	I27.0		

PT/INR CARE PLAN

Item Prescribed: **Supplies:**

☐ Roche Coaguchek XS ☐ Supplies Only

INR Reports Options:

Email for report: _____ Fax Number for report: _____

Target INR Range: Low ___ to High ___

☐ Email or Fax Every Results

Length of Need **Test Frequency:**

☐ Email or Fax Out of Range Results Below: _____ Above: _____

☐ 3 Month ☐ One Test per Week ☐ Email or Fax Monthy Summary Only

☐ 6 Month ☐ One Test per 15 days ☐ Patients will Report Directly to Physician's Office

☐ 12 Month ☐ Other _____ Every result will be faxed unless otherswise indicate above.

Physician Signature: ☐ _____ Date: _____

Printed Physician Name: _____ Rep-FME _____