



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

Please Include the Last Primary Physician Visit Summary.

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