Quality of Care. Quality of Life

PATIENT ENROLLMENT FORM

FOR PT/INR AT HOME MONITORING SERVICE

RCS – 29 Griffin Rd South, Bloomfield, CT 06002

RCS

Physician Information

Date:______________ Practice Name: ____________________

Prescriber NPI: ______________ Prescribing Physician (Last, First, MI): ____________________

Practice Mailing Address: ____________________

Practice Phone: ____________________ Practice Fax: ____________________

Practice Contact: ____________________ Practice Email: ____________________

Patient Information

Patient Gender: ☐ Female ☐ Male Email: ____________________

Patient name:(Last, First, MI): ____________________ DOB: ____________

Patient mailing address: ____________________

Patient home phone: ____________________ Patient Cell Phone: ____________________

Any known allergies? ☐ Yes ☐ No If YES please explain: ____________________

Is patient being treated for active infection? ☐ Yes ☐ No If YES please explain: ____________________

This section must completed by prescribing practitioner's office

Patient Diagnosis

	Diagnosis	Code
☐	Long Term (current) use of Anticoagulants	Z79.01
☐	Permanent Atrial Fibrillation	I48.21
☐	Paroxysmal Atrial Fibrillation	I48.0
☐	Other Persistent Atrial Fibrillation	I48.19
☐	Other Primary Thrombophilia	D68.59
☐	Personal History of other venous thrombosis and embolism	Z86.718
☐	Chronic Pulmonary Embolism	I27.82
☐	Presence of Prosthetic Heart Valve	Z95.2
☐	Other (MUST write in a valid ICD10 code)	____________

Fax Option

☐ Fax Every Result
☐ Only Fax Out of Range Results
☐ Fax Out of Range + Monthly Summary

Notification of Panic Values

☐ Fax and phone call, Voicemail Allowed
☐ Fax and Live call, No voicemail

Medication and Training Information

Patient has been on Warfarin/Coumadin ≥ 90 days: ☐ ***Yes*** ☐ ***No***

Start date patient began Warfarin/Coumadin: ____________

Patient Training: ☐ RCS ☐ Physician

Chart Notes Attached ☐ Yes ☐ No

Target Range Values: **Range:** ______**To**_______

Note: If Target Range is not listed, default is: 2.0 to 3.0

Panic Values: **Below:**______ **or Above:** _____

Note: If Panic Value is not listed, default is: ≤ 1.4 or ≥5.0

Statement of Medical Necessity/Prescription

Patient's condition requires long-term Warfarin therapy to reduce the risks of thromboembolism. I am ordering PT/INR self-testing service to enable this patient to test more frequently in order to help maintain a stable INR. The patient or patient's care-giver is capable of performing these tests, understanding implications of the test results, and contacting INR services as directed. I believe that patient self-testing is reasonable and necessary for this patient. If you require additional information, please contact me.

Physician and patient acknowledge that this service is for weekly self-testing and reporting of test results.
Chart notes to support INR testing must be available upon request.

Physician's Signature: ____________________ Date: ____________

Print Physician Name: ____________________

Physician Line:- 1-888-763-1541

Enrollment Fax: 1-844-508-0481

Revised 12/05/2019