GRANVILLE VANCE public health

115 Charles Rollins Road
Henderson, NC 27536
Office (252) 492-7151
Fax (252) 631-0655

Provider Telemonitoring Referral and Orders

Patient Name:_____ **Date of Birth:** _____

Patient Address:_____

Patient Contact #: (___)_____ **Has Patient Agreed to Telemonitoring:** ☐ Yes ☐ No

Order Date:_____**Telehealth Monitoring:** ☐ Blood Pressure ☐ Heart Rate ☐ Weight ☐ SpO2

How many hospital admissions has patient had in past 12 months? _____

How often would you prefer to receive reports for this patient? ☐ Once/week ☐ Once/month ☐ As Requested

How often would you prefer this patient to receive telemonitoring? ☐ 60 days ☐ 90 days

Patient Diagnosis Criteria may include one or more of the following:

Primary Dx	And at least 1 of these Secondary Dx	
❑ Congestive Heart Failure (CHF)	❑ Congestive Heart Failure (CHF)	❑ COPD
❑ Other Cardiac Disease	❑ High Risk Hospitalization (SHP)	❑ Hypertension
❑ COPD	❑ 3+ hospitalizations in past 90 days	❑ Pneumonia History
❑ Pneumonia	❑ Diabetes (A1C Level ____)	❑ Asthma
❑ Other:	❑ Other:	

Other Inclusion Criteria may include one or more of the following:

- ☐ High risk of readmission
- ☐ Newly diagnosed disease/condition
- ☐ Presence of co-morbidities/multiple health conditions
- ☐ History of poor compliance with recommended plan of care
- ☐ Other:

******Other Health Information – MUST BE COMPLETED*******

Current Weight: _____lbs **Height**: _____ Inches **BMI**: _____

Current Tobacco Use: ____ Yes ____ No **Cessation Counseling Performed**: ____ Yes ____ No

Depression Screening Performed: ____Yes ____No **If yes, follow-up plan documented**: ___Yes ____No

Influenza Vaccine Received: ____ Yes ____ No **If yes, date:** _____

*****PLEASE INCLUDE LIST OF MEDICATIONS WITH REFERRAL FORM*****

Created: 7/1/17
Revised: 8/24/17, 8/7/17, 10/30/17, 12/1/17

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Alert (Trigger) Values	
Blood Pressure	
Systolic less than **85 or** _____	Systolic greater than **180 or**_____
Diastolic less than **40 or** _____	Diastolic greater than **110 or** _____
Heart Rate	
Less than **50 or** _____	Greater than **110 or** _____
SpO2	
Less than 89% or _____	
Weight Increase	
2 lbs. over 1 day or 5 lbs. over 1 week or _____	

PRN Medication Standing Orders for Abnormal Readings

☐ Increased Weight	☐ Irregular HR	☐ B/P Out of Parameters
☐ Furosemide Dosage: ☐ 1 day ☐ 2 days ☐ 3 days	☐ Bradycardia ☐ Tachycardia Notes:	☐ Hypertensive ☐ Hypotensive Notes:
☐ Bumetanide Dosage: ☐ 1 day ☐ 2 days ☐ 3 days	Medication: Dosage: Notes:	Medication: Dosage: Notes:
☐ Torsemide Dosage: ☐ 1 day ☐ 2 days ☐ 3 days	Medication: Dosage: Notes:	Medication: Dosage: Notes:

Any additional Orders: _____

_____

_____

_____

Provider PRINTED Name: _____

Office Phone:_____ **Fax #**:_____

Afterhours #:_____

Provider Signature: _____ **Date**: _____

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