Physician Referral and Order Form

Patient Name _____

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

Referring Physician: _____

Chronic Medical Conditions

- ❍ Alzheimer's Disease and related Dementia
- ❍ Arthritis (Osteoarthritis and Rheumatoid)
- ❍ Arrhythmia (unspecified)
- ❍ Asthma
- ❍ Atrial Fibrillation/Flutter
- ❍ Autism Spectrum Disorders
- ❍ Cancer
- ❍ Cardiomyopathy
- ❍ Chronic Bronchitis
- ❍ Chronic Kidney Disease
- ❍ Chronic Obstructive Pulmonary Disease
- ❍ Chronic Pain
- ❍ Coronary Artery Disease
- ❍ Depression
- ❍ Diabetes Mellitus
- ❍ Heart Failure
- ❍ Hypertension
- ❍ Hyperlipidemia
- ❍ Ischemic Heart Disease
- ❍ Myocardial Infarction
- ❍ Obesity
- ❍ Osteoporosis
- ❍ Pacemaker/ICD Placement
- ❍ Peripheral Arterial or Vascular Disease
- ❍ Psychiatric Disorder
- ❍ Sleep Apnea
- ❍ Smoker
- ❍ Stroke
- ❍ Other _____

_____

Physician Orders for Surveillance and Treatment Plan Include

Chronic Care Management Testing

- ✓ Heart Rate Variability (RM3A/ABI)
- ✓ Medication Adherence and Education
- ✓ Health Coaching
- ✓ Biometric and Symptom Monitoring

Remote Patient Monitoring (check all that apply)

- ❍ Weight
- ❍ Blood Pressure
- ❍ Heart Rate
- ❍ SpO2
- ❍ Blood Glucose
- ❍ Physical Activity

Telemedicine

- ✓ Exercise Counseling (as needed)
- ✓ Nutritional Counseling (as needed)
- ✓ Video Face-to-Face MD appointments (as needed)

***Please send most recent History and Physical or Office Consultation.**

Testing and Biometric monitoring necessity will be based on each patient's diagnoses and individual treatment plan.

I am aware that, as the referring physician, I remain in charge of the patient's healthcare and will be contacted concerning patient progress in the program. I am referring the above patient to participate in the Recovery*Plus*.health services.

Physician Signature: _____

Date: _____ NPI: _____