Physician Referral and Order Form

Patient Name _____

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

Referring Physician: _____ **Physician Phone:** _____

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: _____