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)
- ❍ Atrial Fibrillation/Flutter
- ❍ Autism Spectrum Disorders
- ❍ Cancer
- ❍ Cardiomyopathy
- ❍ Chronic Bronchitis
- ❍ Chronic Kidney Disease
- ❍ Chronic Obstructive Pulmonary Disease
- ❍ Chronic Pain
- ❍ Coronary Artery Disease
- ❍ Diabetes Mellitus
- ❍ Heart Failure
- ❍ Hypertension
- ❍ Hyperlipidemia
- ❍ Ischemic Heart Disease
- ❍ Myocardial Infarction
- ❍ Pacemaker/ICD Placement
- ❍ Peripheral Arterial or Vascular Disease
- ❍ Sleep Apnea
- ❍ Smoker
- ❍ Stroke
- ❍ Other

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

Physician Orders for Surveillance and Treatment Plan Include

Chronic Care Management/ Principle Care Management

- ✓ Exercise (as needed)
- ✓ Nutritional Assessment and Program (as needed)
- ✓ Care Management/ Community Resource
- ✓ Biometric and Symptom Monitoring

Remote Patient Monitoring

Cardiac Rehabilitation

Qualifying Conditions:

- o Acute Myocardial Infarction within the last 12 months
- o Coronary Atherosclerosis of unspecified type of vessel, native or graft (CABG)
- o Heart Transplant within the last 12 months
- o Heart valve repair or replacement surgery within the last 3 months
- o Percutaneous Coronary Intervention (PCI/PTCA) or Stenting in the last 12 months
- o Congestive Heart Failure (HFrEF)

Please submit the most recent clinical note and patient face sheet.

_____

_____

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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: _____