PATIENT ENROLLMENT FORM

FOR PT/INR AT HOME MONITORING SERVICE

mdINR – 59 Windsor Hwy, Suite 240, New Windsor, NY 12553

LNC

mdINR
Quality of Care. Quality of Life

Physician Information

Prescriber NPI: _____ Date: _____

Prescribing Physician (Last,First,MI): _____

Practice Mailing Address: _____

Practice Phone: _____ Practice Fax: _____

Practice Contact: _____ Practice Email : _____

Patient Information

Patient Gender: ☐ Female ☐ Male Email: _____

Name:(Last, First, MI): Patient _____ DOB: _____

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: _____

Patient Diagnosis

☐ Long Term (current) use of Anticoagulants	Z79.01
☐ Chronic Atrial Fibrillation	I48.2
☐ Paroxysmal Atrial Fibrillation	I48.0
☐ Other Primary Thrombophilia	D68.59
☐ Presence of other heart valve replacement	Z95.4
☐ Personal History of other venous thrombosis and embolism	Z86.718
☐ Chronic Pulmonary Embolism	I27.82
☐ 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 live call for all Panic Values
☐ Fax and Voice Mail Option: Panic Values to be left on _____
* if no number given values will be left on office number .

Medication and Training Information

Patient has been on warfarin ≥ 90 days: ☐ Yes ☐ No

Start date patient began warfarin: _____

Please provide chart notes to support home INR testing

Patient Training: ☐ mdINR ☐ Physician

Chart Notes Attached ☐ Yes ☐ No

Target Range Values: **Range:** _____ **To** _____

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

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

Note: If Panic Value is not listed, defaults are: <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 weekly 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 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.

Physician's Signature: _____ Date: _____

Print Physician Name: _____

CHART NOTES NEEDED TO SUPPORT HOME INR TESTING

Physician Line: 888-763-1541

Enrollment Fax: 1-877-222-6580

Revised 12/01/16