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REFERRAL FOR REMOTE PATIENT MONITORING

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

Patient Phone Number and Email Address:_____

Diagnosis: _____Referring Person: _____

Special Instructions/Concerns: _____

Primary Care Provider: _____ Monitoring Setup Urgency: ☐ Routine ☐ Urgent

Mark (X) for desired Medical Monitoring Therapy:

☐ Blood Pressure ☐ Pulse Ox/Heart Rate ☐ Blood Glucose (1x Daily) ☐ Fasting
☐ Temperature ☐ Weight Check ☐ BG 3x/day (before each meal)

Mark (X) to notate how often InstaClinic should send monitoring records to PCP for review if known:

☐ Weekly ☐ Monthly

☐ Other Desired Frequency (Please Specify):_____

_____ _____
Referral Source Signature and Phone # Date

***Please email the referral form to asurdam@instaclinic.com or fax to (307) 459-3785.

***Instaclinic providers will monitor requested vitals and manage acute changes. Instaclinic will refer any urgent findings back to the PCP for review (or to an ER if necessary). Patients will have access to monitoring and can provide PCP with data upon request in addition to data sent by Instaclinic at the above requested intervals.