mdINR

ENROLLMENT FORM

FOR PT/INR AT HOME MONITORING SERVICE

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

Quality of Care. Quality of Life

Patient Information

PATIENT NAME: (Last Name, First, Middle Initial)			**DATE OF BIRTH:** / /	**GENDER:** ☐ Male ☐ Female
PATIENT MAILING ADDRESS: (Street, Suite, Apt, and/or Floor)			**HOME PHONE:**	**CELL PHONE:**
CITY:	**STATE:**	**ZIP CODE:**	**EMAIL:**	
EMERGENCY CONTACT: (Last Name, First, Middle Initial)			**RELATIONSHIP:**	**PHONE:**
Any known allergies? ☐ Yes ☐ No			**If yes, please specify below:**	
Is patient being treated for active infection? ☐ Yes ☐ No			**If yes, please specify below:**	
ORDER TAKEN BY: (Last Name, First, Middle Initial)			**DATE:** / /	**TIME:**

Primary & Secondary Insurance Information

YOU MAY CHOOSE TO FILL IN THE INSURANCE SECTION

- OR TO SAVE TIME-

YOU MAY FAX A COPY OF BOTH SIDES OF THE PATIENT'S INSURANCE CARD, OR FAX A SYSTEM PRINT-OUT OF THE PATIENT'S INSURANCE INFORMATION

PRIMARY INSURANCE:			**NAME OF INSURED:** (if other than the above patient)	**DATE OF BIRTH:** / /
MAILING ADDRESS: (Street, and or Suite)			**GROUP NUMBER:**	
CITY:	**STATE:**	**ZIP CODE:**	**POLICY NUMBER:**	
PHONE NUMBER:			**NAME OF EMPLOYER:**	

SECONDARY INSURANCE:			**NAME OF INSURED:** (if other than the above patient)	**DATE OF BIRTH:** / /
MAILING ADDRESS: (Street, and or Suite)			**GROUP NUMBER:**	
CITY:	**STATE:**	**ZIP CODE:**	**POLICY NUMBER:**	
PHONE NUMBER:			**NAME OF EMPLOYER:**	

Customer Service Number: 800-877-4910

Enrollment Fax Number: 877-222-6580

PHYSICIAN ORDER FORM
FOR PT/INR AT HOME MONITORING SERVICE

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Ordering Physician Information & Patient Name

EFFECTIVE DATE: / /	PROVIDER NPI:	PATIENT NAME: (Last Name, First, Middle Initial)	
PRESCRIBING PHYSICIAN: (Last Name, First, Middle Initial)		PATIENT DATE OF BIRTH: / /	PATIENT GENDER: ☐ Male ☐ Female
GROUP PRACTICE OR HOSPITAL NAME:		PHYSICIAN OFFICE CONTACT NAME:	
MAILING ADDRESS (Street, and/or Suite)		PHYSICIAN OFFICE PHONE:	PHYSICIAN OFFICE FAX:
CITY:	STATE:	ZIP CODE:	PHYSICIAN OFFICE EMAIL:

Any known allergies? ☐ Yes ☐ No	If yes, please specify below:
Is patient being treated for active infection? ☐ Yes ☐ No	If yes, please specify below:

Statement of Medical Necessity and Prescription

This patient's condition requires long term anticoagulation therapy to stabilize INR values and reduce the risks associated with thromboembolism such as stroke, heart attack, and blood clot formation. It is medically necessary for this patient to test his/her INR values frequently to stabilize coagulation and avoid negative outcomes. Enrollment in mdINR's home PT/INR Monitoring Service enables the patient to self-test frequently thereby optimizing therapeutic range. I, and my patient, understand that results from self-testing will be reported to mdINR for the duration of the patient's anticoagulation therapy.

I further certify this patient has been on warfarin therapy greater than 90 days and that this patient (or his/her caregiver) is fully capable of performing these tests, reporting the results to mdINR, and is able to make adjustments to anticoagulation therapy as directed by me in response to reported results.

I understand that mdINR's PT/INR Monitoring Service is for weekly testing patients only. I also understand that all INR results that are ≤ 1.4 and ≥ 5.0 will be considered by mdINR to be Patient Panic Values and I will be notified when results are in this range.

Patients Diagnosis

- ☐ Atrial Fibrillation / Flutter - 427.31
- ☐ Mechanical Heart Valve - V43.3
- ☐ DVT - 453.40
- ☐ Primary Hypercoagulable State 289.81
- ☐ Pulmonary Embolism - 415.11-415.19
- ☐ Other Ven. Embolism / Thrombosis

Fax Options

- ☐ Fax Every Result
- ☐ Only Fax Out of Range Results BELOW: ________ ABOVE: ________
- ☐ Fax Out of Range + Monthly Summary BELOW: ________ ABOVE: ________

NOTE: Every result will be faxed unless otherwise specified above.

Care Plan

Target INR Range: ____________ TO ____________
LOW HIGH

Test Frequency: Weekly

Training by: ☐ mdINR Trainer ☐ Physician Office

NOTE: Training will be performed by an mdINR Trainer if not selected above

mdINR Standard Phone Notification:
We will call your office for any results ≤ 1.4 or ≥ 5.0

☐ Other phone notification range: Below: ______ Above: ______

☐ No phone notification - fax only.

Medication: ____________________

PHYSICIAN SIGNATURE:	DATE:	1234567890

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