PATIENT ENROLLMENT FORM

mdINR
Quality of Care. Quality of Life

FOR PT/INR AT HOME MONITORING SERVICE
mdINR - 45 Turner Dr., Bldg. A, Middletown, NY 10940

ACS

Physician Information

Date:_____ Practice Name: _____

Prescriber NPI: _____ Prescribing Physician (Last, First, MI): _____

Practice Mailing Address: _____

Practice Phone: _____ Practice Fax: _____

Practice Contact: _____ Practice Email: _____

Patient Information

Patient Gender: ☐ Female ☐ Male Email: _____

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

Patient 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: _____

This section must completed by prescribing practitioner's office

Patient Diagnosis

☐ Long Term (current) use of Anticoagulants	Z79.01
☐ Permanent Atrial Fibrillation	I48.21
☐ Paroxysmal Atrial Fibrillation	I48.0
☐ Other Persistent Atrial Fibrillation	I48.19
☐ Other Primary Thrombophilia	D68.59
☐ Personal History of other venous thrombosis and embolism	Z86.718
☐ Chronic Pulmonary Embolism	I27.82
☐ Presence of Prosthetic Heart Valve	Z95.2
☐ 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 phone call, Voicemail Allowed
☐ Fax and Live call, No voicemail

Medication and Training Information

Patient has been on Warfarin/Coumadin ≥ 90 days*:** ☐ ***Yes ☐ ***No***

Start date patient began Warfarin/Coumadin: _____

Patient Training: ☐ mdINR ☐ Physician

Chart Notes Attached ☐ Yes ☐ No

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

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

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

Note: If Panic Value is not listed, default is: ≤ 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 more frequently 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 services 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.
Chart notes to support INR testing must be available upon request.

Physician's Signature: _____ Date: _____

Print Physician Name: _____

Physician Line: 1-888-763-1541

Enrollment Fax: 1-844-700-3484

Revised 12/05/2019