TITLE: **MOUNT CARMEL PHARMACY OUTPATIENT CARE CENTER 24-HOUR BLOOD PRESSURE MONITOR REFERRAL**

NOTE: ☑ THESE ORDERS CAN BE CHECKED BY THE PHYSICIAN TO DESIGNATE FURTHER INSTRUCTIONS. THESE ORDERS WILL BE FOLLOWED UNLESS CROSSED OUT.

DO NOT USE THE FOLLOWING ABBREVIATIONS: U or u; Q.D., QD, q.d., qd; Q.O.D. QOD, qod, q.o.d., IU, MS or MSO4 or MgSO4; trailing zero; lack of leading zero

1. ☑ By this referral, I understand that my patient will have their 24-hour blood pressure monitor placement and removal managed by the pharmacist of the Mount Carmel Pharmacy Outpatient Care Center according to established policies and procedures. I allow the clinic to act as an agent to initiate and execute the insurance prior authorization process. I concur with these guidelines and permit their implementation in this patient. I consider this program to be a necessary part of the patient's medical care.

PLEASE PRINT THE FOLLOWING INFORMATION:

Patient name ______________________________ Phone ____________________

Date of birth______________ Last 4 numbers of Social Security ____________

Insurance____

Diagnosis/ICD-10____

Please send last Office Note, Past Medical History, and Current Medication List

Physician (please print) ______________________________

Phone ______________________

Fax ________________________

Please fax this form to the appropriate Pharmacy Outpatient Care Center:

☐ Mount Carmel East	☐ Mount Carmel St. Ann's	☐ Mount Carmel Grove City
614-234-8844 phone	380-898-6020 phone	614-663-4995 phone
614-234-8850 fax	380-898-6021 fax	614-663-4994 fax

Physician Signature ___________________________ **Date** __________ **Time** ________

Mount Carmel, Columbus, Ohio

24-hour ABPM 101-5-22

NAME

DOB

MR #

FIN #