REAL TIME DIAGNOSTICS
PT/INR SELF-TESTING MEDICATION & DOSAGE MANAGEMENT

RAPID REFERRAL FORM FOR:

PT/INR Patient Self-Testing & Clinical Services

PR/INR Self Testing Qualifications

1. Patient has been on warfarin/Coumadin for a minimum of 3 months
2. Patient has one of the following medical conditions: Chronic Atrial Fibrillation, Venous Thromboembolism, Deep Vein Thrombosis, Pulmonary Embolism or Mechanical Heart Valve
3. Patient has the manual and visual ability to perform a self-test or has a committed support person to assist with testing

1. Patient Information

❑ Patient Face Sheet submitted instead of completing section 1a and 1b

1a

Date: _____ AM: WEB

Patient Name: _____ ❑ Male ❑ Female

Address: _____

City: _____ State: _____ Zip: _____ Birth Date: _____

Primary Phone: _____ Secondary Phone: _____ SS # _____

1b

INSURANCE:

Primary Insurance: ❑ Medicare ❑ BC/BS ❑ Other _____

Contract/Policy # _____ Group # _____ Subscriber: _____

Secondary Insurance: ❑ BC/BS ❑ Medicaid ❑ Other _____

Contract/Policy # _____ Group # _____ Subscriber: _____

2. Physician Information

Prescribing Physician Name: _____ Phone: _____

Address: _____ Fax: _____

_____

_____ Physician is aware of PST referral: ☐ Yes ☐ No (please circle one)

3. Notes or Special Requests

_____

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_____

4. Referred By:

Company Name: _____

Contact Name: _____

Office Phone: _____ Alt Phone: _____

Phone: 866-662-7897

PLEASE FAX TO 877-439-2734

RTD 201706