

## LVAD Remote Patient Monitoring and Supply Program Referral Order Form

Please return completed form to [inrrpm@woundcareresources.net](mailto:inrrpm@woundcareresources.net)

Facility Name: \_\_\_\_\_

Correct Patient Mailing Address: \_\_\_\_\_

### RPM

Will the patient be participating in the RPM Program?     Yes     No

*If so, one of our representatives will be reaching out to the patient once Insurance has been approved for LVAD supplies*

### Select which RPM option the patient will be enrolled in:

- Full RPM Only (all devices except INR)
- Full RPM with INR included
- INR Only supported with RPM documentation (no additional devices)

### Device Description | Please check all devices needed

Doppler with Manual BP Cuff	
Automatic BP Cuff	
Scale	
Thermometer	
Gateway	
INR Device	

*Please note: Select only one type of BP device and one type of scale, when these are needed.\*\**

### When an INR Device is needed, please indicate the testing frequency below:

Number of INR tests required each week \_\_\_\_\_