Deliver To:
☐ Patient
☐ Activa Home Health

_____

VirtuCHECK
Remote Patient Monitoring Order Form

Phone: 954-324-8858
Fax: 877-779-2509

PATIENT NAME:_____ **DOB:**_____ **EMAIL:** _____

PHYSICIAN NAME:_____ **NPI:**_____

Medical devices and wearables in the patient's home will record vital signs and transmit those to the VirtuOx cloud-based server. Alert notifications will be automatically sent to the ordering physician and/or relayed by the Home Health agency staff when a vital sign falls outside the pre-established thresholds.

Please choose which conditions/vitals you would like to be monitored and provide alert notification thresholds if you prefer something other than the default listed below:

☐ **Cardiac** ICD-10 Code(s)_____	☐ **Respiratory** ICD-10 Code(s) _____	☐ **Diabetes** ICD-10 Code(s)_____	☐ **COVID-19 Screening** ICD-10 Code(s)_____
Blood pressure, Weight, SpO2, HR	SpO2, HR	Blood glucose	Temperature, SpO2, HR

Vital Sign	Alarm Default Lower Limit	Alarm Default Higher Limit	Keep Alarm Default Presets (check choice)	New Alarm Lower Limit	New Alarm Upper Limit
Blood Pressure	50-100	90-160	☐ YES or ☐ NO		
SpO2	89%	100%	☐ YES or ☐ NO		
Temperature	96	101°	☐ YES or ☐ NO		
Heart Rate	50 bpm	110 bpm	☐ YES or ☐ NO		
Glucose	60 mg/dl	120 mg/dl	☐ YES or ☐ NO		
Weight	± 3 lbs. in 24 hours or 5 lbs in 1 week		☐ YES or ☐ NO	± lbs.	

Alert Notifications to be sent to:

Contact name:_____

Email address:_____

Phone Number:_____

Preferred Method of Contact

(Check below)

☐ EMAIL or ☐ PHONE

Telephone Order: Remote monitoring of patient's vital signs, set-up and patient education on use of equipment

V/O Received: _____ **by:**_____
(date and time) (health care provider name and signature)

Prescriber Signature & Certification: (Stamped dates / signatures not valid)

I, the undersigned, certify that I am the patient's treating practitioner and that the information contained on this form is based on a face -to-face office visit. I am prescribing Remote Patient Monitoring as medically necessary to monitor and evaluate vital signs.

Physician Signature:_____ **Date:**_____

Please fax Order form and Patient Face Sheet to: (877) 779-2509