Paramount Health Care-CHF Home Monitoring Program
ProMedica Home Care Physician Order

Patient Name: _____________________ Diagnosis: __CHF________

Paramount Member ID#________________________ Authorization #________________

☐ Elite  ☐ Advantage  ☐ HMO                SOC Date: __________________________

Address: _________________________________________________________________

City: _____________________________ Zip Code: __________________

Phone: ____________________________Birthdate______________________________

Referral Date: ________________ (Schedule first home visit as soon as able)

Paramount Case Manager: ______________ Phone: _________________

Home Care Contact: ___________________      Phone: _________________

☐ OK to initiate ProMedica Home Health Care Chronic Heart Failure (CHF) program
  • RN to make home visit to initiate home telehealth and disease management teaching
  • RN to make home visit to discharge and discontinue home telehealth
  • 1PRN RN visit for symptom management

☐ Assess Home Medications and compliance
☐ Additional Comments/Orders:

___________________________________________________________________________________

Physician Signature: _____________________________Date:_________________________

FAX Completed Order Form to: ProMedica Home Health Central Intake 419-885-9136

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