Rx

1-800-CARDIOLINK
Phone: 516-997-LINK(5465)
Fax: 516-394-7476
www.Cardiolink.net

Physician Signature: _____ **DX :** _____ **Date:** _____

PLEASE PRINT

Please Enroll (Last Name) _____ **(First Name)** _____

Address: _____ **Apt. #** _____ **City:** _____ **State:** _____ **Zip:** _____

Home #: (_____)_____ **Cell #:**(_____)_____ **Work #:** (_____)_____

Soc. Sec. # _____ **DOB:** _____ **Gender: M**_____ **F**_____ **E-Mail:** _____

Pacemaker (Circle) YES NO Medications: _____ **Allergies:** _____

Referring Physician: _____ **Physician E-Mail:** _____

Phone #: (_____)_____ **Fax #:** (_____)_____

Primary Care Physician _____ **Phone #:** _____ **Fax #:** _____

Contact Person at Home: _____ **Relation:** _____

Telephone #: (_____)_____ **Cell #:** (_____)_____ **Work #:**(_____)_____

Contact Person NOT at Home: _____ **Relation:** _____

Telephone #: (_____)_____ **Cell #:** (_____)_____ **Work #:**(_____)_____

EMERGENCY AGENCY _____ **Phone:** _____

CARDIAC SUPPORT SERVICES

Please Check One

_____ **Wireless Telemetry** Please Circle **(7, 14, 21 Days) Parameters: Rate H** _____ **L** _____ **AFib: On or Off**

- **ATTENTION DOCTOR: PLEASE AUTHORIZE CARDIOLINK TO PROVIDE YOUR PATIENT WITH AN ARRHYTHMIA MONITOR IF THE INSURANCE COMPANY DOES NOT REIMBURSE FOR WIRELESS TELEMETRY** _____

_____ **Arrhythmia Monitoring Event** _____ **Loop** _____ **(24 Hour Tanstelephonic EKG Monitoring including one prescribed call per week plus unlimited symptomatic calls)**

_____ **Auto Trigger Monitoring**

_____ **Pacemaker Monitoring**

_____ **Holter Monitoring**

_____ **Ambulatory Blood Pressure Monitoring**

_____ **Home INR Testing**

PATIENT INSURANCE INFORMATION

Primary Ins. _____ **ID #** _____ **Group #** _____

Holder: _____ **DOB:** _____

Insured SS #: _____ **Ins. Phone (**____)_____ **Employer:** _____

Secondary Ins. : _____ **ID#** _____ **Group #** _____

Holder: _____ **DOB:** _____

Insured SS #: _____ **Ins Phone (**____)_____ **Employer:** _____

I authorize the above ordering physician to release any necessary medical or demographic information concerning above named patient to CardioLink Corp. I acknowledge responsibility for the assigned CardioLink monitor. Upon completion of service, I will return the monitor in good working order to CardioLink. Failure to do so will result in my being charged $2150.00 for replacement of the monitor.

Signature of Patient/Parent or Guardian: _____ Date: _____