Alabama Department of Public Health

Remote Patient Monitoring (RPM) Referral

REMOTE PATIENT MONITORING PROGRAM

Referral Source, Contact Information:			Date:
RMEDE ID #:	Medicaid #:	SS # (HCHB):	
Patient Name (First, Middle Initial, Last):			
Date of birth:		Gender: ❑ Male ❑ Female	
Patient Address:		City:	
State:	County:	Zip code:	Phone:

Marital Status: ❑ Married ❑ Separated ❑ Single ❑ Widowed ❑ Divorced

Race: ❑ White/Caucasian ❑ Black ❑ Hispanic ❑ Asian/ Island Pacific ❑ Native ❑ Not White/Not of Hispanic origin ❑ Prefer not to answer

Allergies: ❑ NKDA ❑ No known food allergies ❑ Other (list): _____

Emergency Contact/Caregiver Name:		
Relationship:	Phone:	
Enrolling Provider Name:		❑ MD ❑ DO ❑ NP ❑ Other
Address:		
Phone:	Fax:	
District/Office:		
Patient Contact Date:	PCP Order Request Date:	PCP Order Faxed Date:
Scheduled Admit Date:	Referral Source Notification of Admit Date:	

Primary Diagnosis:
❑ Diabetes (Type 2 or IDDM) ❑ Hypertension (HTN)
❑ Congestive Heart Failure (CHF) ❑ Pediatric Asthma (PA)
❑ Gestational Diabetes Mellitus (GDM) ❑ Maternal Hypertension

Secondary Diagnosis (optional):
❑ DM ❑ HTN ❑ Maternal HTN
❑ CHF ❑ GDM ❑ Obesity
❑ Other (specify): _____

Additional Notes or Comments: