Spiro PD 2.0 Referral Form

V.06.01.21.B

RemetricHealth
bringing healthcare home

Phone: 484-664-7600 Fax: 484-664-7500

Patient Demographics

Name: _____ ☐M ☐F
DOB: _____ SS#: _____
Phone: _____ 2nd Phone: _____
Email: _____
Address: _____
City: _____ State: _____ Zip: _____
Primary language, if other than English: _____

Authorized alternate contact information
Name/relation: _____
Phone: _____ Email: _____

Provider Information

Prescriber: _____
_____
Phone: _____ Fax: _____
Facility/Clinic Name:_____
Address: _____
_____
NPI: _____ Office contact: _____

Training by: ☐ Prescriber's office ☐RemetricHealth ☐ Not needed

****Please fax a copy (front and back) of the patient's insurance card(s) as well as any relevant clinical notes/documents****

Clinical Information

Diagnosis/ ICD-10 Code:
_____
_____

Clinical Info/Comments:
_____
_____

Device(s) Ordered

☐ **Spiro PD 2.0 Personal Spirometer** – personal digital spirometer, mouthpiece, stand, and charging cord (Quantity #1)

Provider Signature: _____ **Date:** _____

My signature for this prescription also authorizes RemetricHealth and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process. Confidentiality statement: This message is intended only for the individual or institution to which it is addressed. This may contain information, which is confidential, privileged, and/or proprietary. This information may be exempt from disclosure under applicable laws including but not limited to HIPAA. If you are not the intended recipient, please note you are strictly prohibited from distributing, copying, or disseminating this information. If you received this information in error please notify the sender noted above and destroy all transmitted material.

Please include a Statement of Medical Necessity

Provider Signature X	**Date**
Printed Name	