MONTANA HEALTH CENTERS | Operated by Premise Health.

Non-Premise Health Provider Enrollment Form-Blood Pressure Monitoring Program

Contact Information

Patient Name:	Patient Date of Birth (MM/DD/YY):
Provider Name (please print):	Clinic or Health Establishment's Name:
*Provider Telephone Number: ( ) -	*Provider Fax Number: ( ) -

* *Please note:* ***Please use your direct office line & fax number*** *We will use the contact information you provide to update you on this patient's status.*

Referral Information

Program required diagnosis: (Please select one)	☐ Diagnosis of Hypertension ☐ Elevated Blood Pressure without Diagnosis of Hypertension
Number of blood pressures readings you would like the patient to take per day: Please include any specific times you would like these readings to be taken (If applicable)	
Patient's upper arm circumference: *If the circumference is over 17 inches/43 cm please include a forearm circumference.	Upper Arm Circumference: (Inches or centimeters) *Forearm Circumference: (Inches or centimeters)
Hypertensive Medications the patient is currently prescribed: (If applicable)	
Notify Provider (Me) if: Preferred contact method for these notifications: (Please select one) ☐ Telephone call/voice mail ☐ Fax notification Monthly Blood Pressures reports will be faxed to your office in addition to your selection.	Blood pressure readings are above or below: > = ______/______ (Systolic) (Diastolic) P: ______ (Pulse) < = ______/______ (Systolic) (Diastolic) P: ______ (Pulse) ***Patient's Blood Pressure Goal:*** ______/______ (Systolic) (Diastolic) P: ______ (Pulse)

Consent

I am the patient's primary care provider and would like the patient to be enrolled in the Premise Health Blood Pressure Monitoring Program. I understand that this Program and Premise Health are assuming the role of a liaison between my patient and myself as the PCP. I understand the Blood Pressure Management Program is responsible for monitoring the patient's condition, not managing it. Premise Health is responsible for sharing synced data and patient condition or status when available. By signing this consent, I agree as the patient's PCP to managing the patient's blood pressure and overall plan of care.
Provider Signature: **Date:**

Return Form To:

Fax: (406) 391-7126
Email: SM.CH.RemoteMonitoringMT@premisehealth.com