AMI CARDIAC MONITORING

Fax to AMI Cardiac Monitoring: (800) 785-4329
You will receive confirmation by fax or email.

PRINT SUBMIT

PATIENT DEMOGRAPHICS			Send monitor directly to patient: ☐ Yes ☐ No
Patient Name:	Date of Birth:	Sex: ☐ M ☐ F	Pacemaker: ☐ Yes ☐ No
Best Contact Phone#:	Secondary Phone#:		ICD: ☐ Yes ☐ No
Address:	City:	State:	Zip:
Emergency Contact:	Relationship:	Phone:	
☐ Skilled nursing or assisted living resident	Facility Name:		Phone:

ENROLLING PHYSICIAN		ENROLLING FACILITY		
☐	☐	Facility Name:		
☐	☐	Address:		
☐	☐	Address:		
☐	☐	City:	State:	Zip:
☐	☐	Phone #:	Fax #:	
☐	☐			

PROCEDURE: ☐ **Mobile Cardiac Telemetry** ☐ **Cardiac Event Monitor** ☐ **Holter Monitor** **Serial No.__________________**

INDICATIONS FOR MONITORING:		RX DURATION: #______DAYS	
☐ G45.9	Transient cerebral ischemic attack, unspecified	☐ I48.2	Chronic atrial fibrillation
☐ I44.0	Atrioventricular block, first degree	☐ I48.3	Typical atrial flutter
☐ I44.1	Atrioventricular block, second degree	☐ I48.4	Atypical atrial flutter
☐ I44.30	Unspecified atrioventricular block	☐ I48.91	Unspecified atrial fibrillation
☐ I45.5	Other specified heart block	☐ I48.92	Unspecified atrial flutter
☐ I45.6	Pre-excitation syndrome	☐ I49.2	Junctional premature depolarization
☐ I45.81	Long QT syndrome	☐ I49.5	Sick sinus syndrome
☐ I45.89	Other specified conduction disorders	☐ R00.0	Tachycardia, unspecified
☐ I45.9	Conduction disorder, unspecified	☐ R00.1	Bradycardia, unspecified
☐ I47.0	Re-entry ventricular arrhythmia	☐ R00.2	Palpitations
☐ I47.1	Supraventricular tachycardia	☐ R06.00	Dyspnea, unspecified
☐ I47.2	Ventricular tachycardia	☐ R42	Dizziness and giddiness
☐ I47.9	Paroxysmal tachycardia, unspecified	☐ R55	Syncope and collapse
☐ I48.0	Paroxysmal atrial fibrillation	☐ Z79.01	Long term (current) use of anticoagulants
☐ I48.1	Persistent atrial fibrillation	☐ Other	

MEDICATIONS (Cardioactive):

HEALTH INSURANCE DEMOGRAPHICS: Primary	Secondary
Insurance Carrier:	
Policy/Identification #:	
Group #:	
Policy Holder/DOB:	

I hereby state that I have examined the above patient and have determined that the test ordered above is medically necessary due to the patient's symptoms and/or medical condition. The results of this test will be used to aid in the diagnosis and treatment of this patient. This patient is at a low risk of developing ventricular tachycardia/fibrillation and would not be more appropriately cared for in a hospital setting. I understand that this is not a screening procedure.

______ (Initial) I authorize the use of a rate-triggered cardiac event monitor if the patient does not meet clinical criteria for mobile cardiac or holter telemetry. I have accepted AMI's clinical notification criteria for this patient. I authorize changing device to the alternate device above if the patient does not have signal adequate for transmission of data with prescribed device.

PHYSICIAN'S SIGNATURE: X __________________________________ Date:__________________

NOTE: This enrollment form must be complete including physician signature before processing. All enrollments faxed to AMI will be verified by fax. If you do not receive fax confirmation of receipt within 12 hours, please contact AMI immediately.

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