PHYSICIAN ORDER
COMMUNITY LONG TERM CARE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
TELEMONITORING SERVICE

To: Dr. _____

Fax: _____ Sent/Faxed Date_____

From Name: _____

Patient's Name: _____DOB:_____

Baseline Vital Signs: Weight: BP: Pulse: Glucose:

Critical Values		Patient Critical Values if Different
Wt:	>2# over Baseline/day	>_____# over Baseline/day
	>5# under Baseline/week	>_____# under Baseline/week
BP:	Systolic > 150 & < 90	>_____ & <_____(Systolic)
	Diastolic > 90 & < 50	>_____ & < _____(Diastolic)
Pulse	< 60 & > 120	<_____& > _____ (Pulse)

Equipment: Weight Scale: _____ Blood Pressure Device:_____
Pulse Recorder: _____ Pulse Oximeter: _____
Glucometer: _____

For Patient: Measure weight at the same time every morning before breakfast and after the first void. Measure rhythm strip & blood pressure one hour after morning medications.

Provide: Daily self-monitoring reported to physician or readings falling outside of the critical values identified above.

Physician's Signature_____ Date _____
(Stamped Signatures are not acceptable)

Date Received back in Office _____ By _____