COVID-19 Remote Patient Monitoring (CRPM) Enrollment Form

Referring provider to complete this section		**Date:** (YYYY-MM-DD)
Patient Name (Last Name, First Name, MI):	**DoDID:**	**DOB/Age:** / years
Diagnosis:	**COVID-19 Status:** ☐Positive ☐Negative ☐Pending ☐N/A	**Admitting Physician:**

Please Select :

High Risk: ☐	**Medium Risk:** ☐	**Low Risk:** ☐
High Risk: Resting or exertional O2 requirement upon discharge; or high-risk co-morbid conditions (e.g.: HF, CLD, PHTN) Monitoring: Continuous, passive vital signs +/- integrated peripherals Engagement: Twice daily review (or by alert) of clinical status, weekly video call	Medium Risk: Resting or exertional dyspnea upon discharge; or moderate-risk co-morbid conditions (e.g.: DM2, HTN, obesity) Monitoring**:** Continuous, passive vital signs +/- integrated peripherals Engagement**:** Once daily review (or by alert) of clinical status, weekly video call	Low Risk: No significant resting or exertional dyspnea; or no significant co-morbid conditions Monitoring: Intermittent vital signs Engagement: As needed by alert

Monitored VS Basic Parameters:	**Please indicate alternate parameters if desired:**
Abnormal VS: • **Temperature: ≥ 101° F or ≤ 96.5° F** • **Respiratory Rate: ≥ 20 or ≤ 8** • **Heart Rate: ≥ 120 or ≤ 40** • **SpO2: ≤ 88%** **Extremely Abnormal VS:** • **Temperature: ≥ 103° F or ≤ 95° F** • **Respiratory Rate: ≥ 30 or ≤ 5** • **Heart Rate: ≥ 150 or ≤ 30** • **SpO2: ≤ 85%**	

Will CPRM Enrollment Prevent an In-Patient Admission? ☐YES ☐ NO ☐ N/A

Will CPRM Enrollment Decrease In-Patient Bed-Days? ☐ YES ☐ NO ☐ N/A **If yes, approx. how many? _____**

Comments: (Pertinent History of Present Illness)

Provider Signature:	**Print Name:**	**Phone Number:**

Nursing/Support staff to complete remainder of form

Referring MTF:	**Sending/Admitting Department:**	**Anticipated Time/Date of D/C:**

Gender: ☐ Male ☐ Female	**Ht:** _____ **Wt:** _____	**Preferred language:** *Language chosen will be language patient will see on tablet.* ☐ English ☐ Spanish

Phone Number: ☐ Cell ☐ Home	**Email Address:**	**County:**

Physical Address (NOT mailing address):	**City:**	**Zip:**

Ethnicity:

☐ White (Not Hispanic or Latino)

☐ Native Hawaiian or Other Pacific Islander (Not Hispanic or Latino)

☐ American Indian or Native Alaskan (Not Hispanic or Latino)

☐ Asian (Not Hispanic or Latino)

☐ Hispanic or Latino

☐ Black or African American (Not Hispanic or Latino)

Any pacemaker or other implants? Indicate type/place

☐ Yes ☐ No _____

**Do not charge device while wearing*

Any upper arm sleeve tattoos?

☐ Yes ☐ No ☐ Right ☐ Left

**Patients with bilateral upper arm tattoos are ineligible to wear device*

Alternate/Emergency Contact Person & Relationship:	**Phone number: (Different from above)**

CORE KIT ID: *(ex: green uat nine)*	**MULTI KIT ID:** *(ex: cyan uat five)*

Additional Comments: (Home O2, pain, etc.)

Inpatient Unit Name: **Nurse's Station Telephone Number:**

Prepared by: (Name, Signature, Title)

Department:	**Contact Number:**	**Time/Date Prepared:**

Please upload this complete form and the Informed Consent into the **Virtual Health Care Coordination Application (VHCCA)** site in CarePoint at the following link: