**Tolman Clinical Laboratory**
**North Atlantic Medical Services**
**125 Tolman Avenue**
**Leominster, MA 01453**

Fax Number: (888) 538-2221
Transmit: 1-800-453-6466
Client Service: 1-800-229-6267

**Account Name:**
**Address:**
**Address:**
**Phone:**
**Fax:**
**NAMS Acct.#**
**Ordering Physician:**_____

**UPS Tracking Number #:**

_____

**Restock**

# 30 Day Event Monitoring Enrollment Form

**Please complete ALL sections of this form including any required authorization or referral #'s.**

**Patient Information** **MR #** _____

Patient's Name: (Last Name)_____(First Name)_____(MI) ____

Address: ***(No PO Box)***_____(City)_____(State)_____(Zip)_____

Home Phone:_____Work Phone:_____Date of Birth:_____Sex:_____

**InsuranceReferral#:** **Authorized By:**

Primary Insurance:_____Ins.ID#_____Group#_____

Address:_____Phone:_____

Subscriber:_____Relationship: Self θ Spouse θ Child θ

Secondary Insurance:_____Ins.ID#_____Group#_____

Address:_____Phone:_____

Subscriber:_____Relationship: Self θ Spouse θ Child θ

I authorize the release of any payment and medical information necessary to process this and related claims. I authorize payment of medical benefits to Tolman Clinical Laboratory for technical services. I agree to be responsible for any non-covered services, co-insurance, co-payments, and deductibles not covered by my benefits. Equipment must be returned immediately at the end of the monitoring period to Tolman Clinical Labs. Timely return of the monitor will allow for prompt processing of the data pertaining to your health. I understand that if I fail to return the monitor or if damage occurs to the unit I will be financially responsible for the replacement cost. ***Equipment Return Date:***_____

Patient Signature (Parent if a Minor)_____ Date_____

***FAX this form prior to calling in baseline***

Days to be monitored: _____

Pt Setup/instructed by: _____

θ King of Hearts θ HeartTrak Smart

θ HeartTrak Smart **AT** ____40/140 ____50/180

θ HeartTrak Smart **AF** ____40/140 _____50/180

**Serial #:** _____

Does pt have pacemaker: θYes θNo
Pacemaker Type:_____Parameters:_____
Cardioactive Meds: _____

**Diagnosis** (Indicate one or more)

____Dizziness (780.4)
____Syncope and collapse or near syncope (780.2)
____Angina Pectoris (413.9)
____Post MI, early (410.9)
____Arrhythmia, unspecified (427.9)
____Premature beats (427.60)
____Afib (427.31)
____Aflutter (427.32)
____Paroxysmal SVT (427.0)
____Paroxysmal Vtach (427.1)
____Paroxysmal Tachycardia, unspecified (427.2)
____AV Block, Complete (426.0)
____2nd Degree AV Block (Mobitz Type II) (426.12)
____2nd Degree AV Block (Mobitz Type I) (426.13)

**I certify that this test is medically necessary for the proper evaluation and treatment of this patient.**
Physician Signature:_____Date:_____