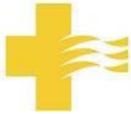

Tolman Clinical Laboratory
North Atlantic Medical Services
125 Tolman Avenue
Leominster, MA 01453

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

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:_____

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______________

Fee for Service

Event – 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:______________