



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: _____

24 Hour Ambulatory Blood Pressure Monitoring Enrollment

P a t i e n t I n f o r m a t i o n Patient's SS#: _____

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 to the facility where you had the monitor applied at the end of the monitoring period. 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 it I will be financially responsible for the replacement cost.

Patient Signature _____ Date _____ Equipment Return Date: _____

FFS

Return this form with monitor

Start Date and Time: _____

Pt Setup/instructed by: _____

Serial #: _____

Cardiac/Hemodynamic Meds: _____

Diagnosis (Indicate one or more)

___ White Coat Syndrome
 ___ Essential Hypertension
 ___ Other _____

I certify that this test is medically necessary for the proper evaluation and treatment of this patient.

Physician Signature: _____ Date: _____