HYPERTENSION IN PREGNANCY PRESCRIBER ORDER FORM

PHONE: 888-304-1800

Patient Name:			**Date of Birth:**		
Address:					
Phone:	**Height:**	☐ **in** ☐ **cm**	**Pre-Pregnancy Wt:**	**Current Wt:**	☐ **lbs** ☐ **kg**

Clinical Information

ICD-10 & Description:

☐ **O14.9 Unspecified pre-eclampsia unspecified trimester**

☐ **Other:** _____

☐ **O16.1 Unspecified maternal hypertension 1st trimester**

☐ **O16.2 Unspecified maternal hypertension 2nd trimester**

☐ **O16.3 unspecified maternal hypertension 3rd trimester**

G/P:	**EDC:**	**Activity Level:**

Current Medications	**Dose**	**Route**	**Freq**	**Current Medications**	**Dose**	**Route**	**Freq**

Order Form

Blood Pressure Testing & Management	**BLOOD PRESSURE CHECKS (check all that apply):** ☐ **Morning** ☐ **Afternoon** ☐ **Evening** ☐ **Bedtime** **NOTIFY PRESCRIBER FOR:** **Systolic Blood Pressure ≥ 140 mmHg and/or Diastolic Blood Pressure > 90 mmHg** **Or as ordered below:**
Urine Protein Testing	**Check urine protein daily** **NOTIFY PRESCRIBER FOR: urine protein ≥ 2+ or as ordered:**
Daily Weights	**Check weight daily** **NOTIFY PRESCRIBER FOR: >3-5lb weight gain in 1 week or as ordered:**

Ancillary Orders

- Skilled Nurse Visit (SNV) or TeleHealth Nurse Visit x1 to initiate plan of care; PRN up to 2 nurse visits for complications identified in telephonic assessments.
- Educate patient regarding diagnosis and signs/symptoms that should be reported: epigastric pain, headaches, visual disturbances, increase in swelling, generalized malaise.
- Option Care Women's Health to follow patient progress via telephonic assessment of blood pressures, weight, urine protein, and signs/symptoms of pre-eclampsia. Provide 24/7 telephonic nurse availability throughout length of service.
- Educate patient on reporting of blood pressures, weight, and urine protein.
- Initiate service once benefits and eligibility verification have been completed, authorization obtained (as applicable), patient's acceptance of financial responsibility (as applicable), patient availability to start service, and patient having necessary equipment (blood pressure cuff, scale, protein dipsticks).
- **Other:**

Referral/Discharge Plan: Discontinue therapy with provider discharge order or completion of designated program per insurance, patient refusal, noncompliance, or if delivery occurs.

Other:

I certify that the use of the indicated treatment is medically necessary, I will be supervising the patient's treatment, and my state medical license is current and valid.

Prescriber Information

Prescriber Signature:	**Date:**
Prescriber Name:	**NPI:**
Address:	Office Contact:
City: State: Zip:	Direct Contact Number/Extension:
Phone:	Fax:

Fax completed form, insurance information, and clinical documentation to: 877-865-9133