

HYPERTENSION IN PREGNANCY PRESCRIBER ORDER FORM

PHONE: 888-304-1800



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

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 O16.1 Unspecified maternal hypertension 1st trimester
 Other: _____ 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): <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> 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: _____

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