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Education Referral Form
Center for Vascular Diseases

Today's date _____ Patient name: _____

TO BE FILLED OUT BY PATIENT - Privacy and Consent

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to Expert Medical Navigation (EMN). Signing below indicates I authorize the Practice to disclose my medical information to Expert Medical Navigation and its consultants for the purposes of providing health education.

Notice of Privacy Practices: EMN makes available to you their Notice of Privacy Practices and you have the right to read this before you decide whether to sign this Consent. This Notice provides a description of how they maintain, manage communications and keep all of the information protected and private. A copy of this Notice can be found at *http://www.exmednav.com/online-consent/* or can be provided upon request. We encourage you to read it carefully and completely before signing this Consent.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of a family member, your personal representative or another person designated: the education information, discussions, diagnosis, or general condition. You must consent to this in writing and identify that or those individuals.

I hereby authorize the Practice to disclose my medical information to Expert Medical Navigation and its consultants for the purposes of providing health education.

Signature: _____ **Date**: _____

I hereby authorize Expert Medical Navigation to disclose my name and allow them to make a request to me for the purpose of contacting our office (EMN) for the purpose of health education by one or more of the following:

__ Home phone: ( ) _____ - _____ and leave a message Yes ___ No ___

__ Cell Phone: ( ) _____ - _____ and leave a message Yes ___ No ___

__ Work phone: ( ) _____ - _____ and leave a message Yes ___ No ___

Email: _____ @ _____

We will disclose your health education information to you, and we understand that you may request that we include a family member, friend or other person to the extent necessary to participate in the educational information process, but only if you agree that we may do so and identify the individual(s).

_____ Relationship: Family ___ Friend___ Other___

OFFICE STAFF INSTRUCTIONS:

1. Please obtain patient information above and consent. Complete Education Referral Form (both sides) including primary diagnosis/condition and treatment (as applicable).
Fax to 1.866.996.8669.

2. Complete the "HOW TO GET STARTED" Patient Education Referral form, including name and (same) primary diagnosis/condition and treatment and give to patient.
Instruct patient to login or contact EMN within 72 hours as part of their treatment plan.

MD/PA/NP _____ **In-office re-schedule date** _____

Is Surgery or Procedure SCHEDULED? If so type/date _____ / _____

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Patient name: _____

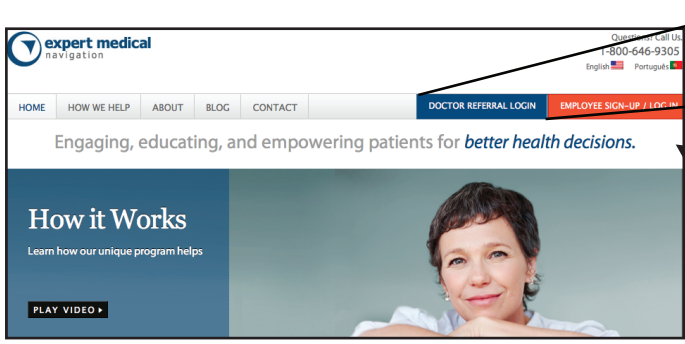
PROVIDER INSTRUCTIONS: Please check current patient status below and advise to complete within **3 days.**

Diagnosis	*Treatment and Education*		*Meds & IVs*	*Diet & Healthy Living*
Aneurysm ☐ Aortic ☐ Other	AAA repair ☐ Endo ☐ Open	Anesthesia ☐ General ☐ Spinal	☐ Arixtra	☐ Diet-Low Cholesterol
☐ Carotid Artery Disease (CAD)	☐ Ablation, vein	☐ Surgical Preparation	☐ Coumadin	☐ DVT Prevention
☐ DVT	Angiography ☐ Aortic ☐ Other	☐ Your Trip to the Hospital	☐ Lovenox	☐ Exercise
☐ Dialysis	Angiogram ☐ Cerebral ☐ With/without intervention ☐ Other	☐ Discharge Instructions	☐ Warfarin	☐ Physical Therapy
☐ Edema (leg)	☐ Angio-Seal	☐ DVT Prevention	Injections ☐ Self	☐ Smoking Cessation
☐ Fibroids-uterine	☐ Amputation (leg)	Infection Prevention ☐ Hospital ☐ Post-Op	Catheter home care ☐ General ☐ Hickman	☐ Other:
☐ Peripheral Arterial Disease (PAD)	☐ AV Fistula or ☐ AV Graft	☐ Incision Care	Infusion Therapy ☐ Home Overview ☐ Device ☐ IV Push	
☐ Renal Failure	Bypass ☐ A/B ☐ Fem/Pop	☐ Patient Safety	☐ JICC Insertion	
☐ Vasculitis	☐ Carotid Endarterectomy	☐ CT Scan	☐ Hickman Insertion	
☐ Venous Insufficiency	☐ Debriedment	☐ Foot Care-diabetic	PICC Insertion ☐ Inpatient ☐ Outpatient	
☐ Wound or ulcer	☐ Sclero Therapy	☐ Pressure Ulcer Prevention	☐ Peripheral Line Insertion	
☐ Other:	☐ Sympathectomy	☐ Other:	☐ Portacath place / remove	
	☐ Other:		☐ Blood Transfusion	
			☐ Other:	

Patient Education Referral Form
HOW TO GET STARTED

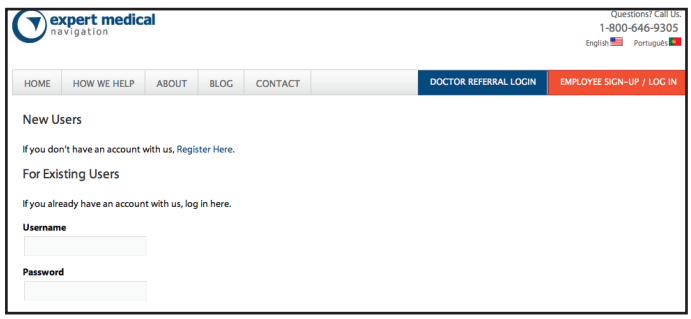
Your doctor and this program can help you make decisions that are best for your health, family and your life.
If you have acces to the internet, please use this form to get started. If not, simply call us at **1.800.646.9305**

1



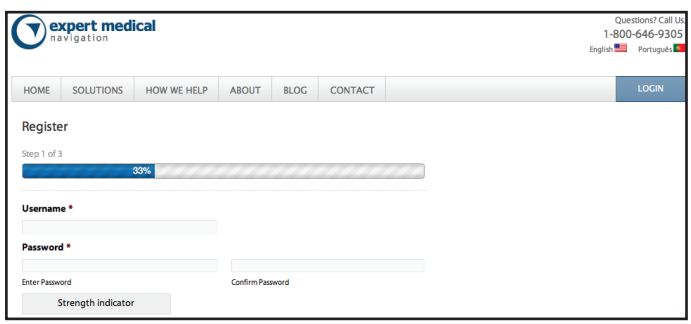
Go to **www.exmednav.com**
and click on LOGIN (upper right corner)

2



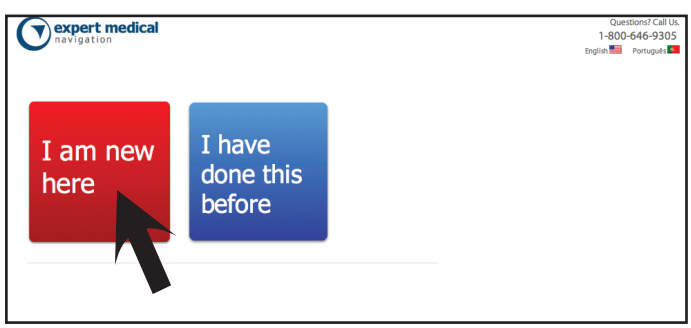
Register yourself:
-Enter your personal information
-Press next

3



-Enter Unique Practice # **001-PRIM-0001**
-Enter Doctor's name

4



-Click one button
-Read the section "What to expect"

5

Click to Start:
-You will be directed to take a health survey. It will take you about10 minutes to complete.
-Please be sure to answer ALL questions.
-Please use the back of this form to enter your diagnosis, test or treatment

Questions? Simply call us at 1.800.646.9305. Our Care Navigators are ready to assist you.
Expert Medical Navigation: Empowering patients for better health decisions.
Fax: 1.866.966.8669

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Patient Education Referral Form
HOW TO GET STARTED

Patient name: _____

OFFICE STAFF: Please complete BOTH sides, including primary diagnosis/condition and treatment (as applicable) and give to patient. Remind of **Unique Practice ID** and to call or login within **3 days.**

Diagnosis	*Treatment and Education*		*Meds & IVs*	*Diet & Healthy Living*
Aneurysm ☐ Aortic ☐ Other	AAA repair ☐ Scope ☐ Open	Anesthesia ☐ General ☐ Spinal	☐ Arixtra	☐ Diet-Low Cholesterol
☐ Carotid Artery Disease (CAD)	☐ Ablation, vein	☐ Surgical Process (overview)	☐ Coumadin	☐ Exercise
☐ Deep Vein Thrombosis (DVT)	Angiography ☐ Aortic ☐ Other	☐ Your Trip to the ☐ Hospital	☐ Lovenox	☐ Deep Vein Thrombosis (DVT) Prevention
☐ Dialysis	Angiogram ☐ Cerebral ☐ With/without intervention ☐ Other	☐ Discharge Instructions	☐ Warfarin	☐ Physical Therapy
☐ Edema (leg)	☐ Angio-Seal	☐ Incision Care	Injections ☐ Self	☐ Smoking Cessation
☐ Fibroids-uterine	☐ Amputation (leg)	Infection Prevention ☐ Hospital ☐ After Surgery	Catheter home care ☐ General ☐ Hickman	☐ Other:
☐ Peripheral Arterial Disease (PAD)	☐ AV Fistula or ☐ AV Graft	☐ Deep Vein Thrombosis Prevention (DVT)	Infusion Therapy ☐ Home Overview ☐ Device ☐ IV Push	
☐ Renal Failure	Arterial Bypass ☐ Coronary Artery ☐ Femoral Popliteal	☐ Patient Safety	☐ Jugular/Neck Catether Insertion	
☐ Vasculitis	☐ Carotid Endarterectomy	☐ CT Scan	☐ Hickman Insertion	
☐ Venous Insufficiency/ Varicose veins	☐ Debriedment	☐ Foot Care-diabetic	Peripheral/Arm Catheter Insertion ☐ Inpatient ☐ Outpatient	
☐ Wound or ulcer	☐ Sclero Therapy	☐ Pressure Ulcer Prevention	☐ Peripheral Line Insertion	
☐ Other:	☐ Sympathectomy	☐ Other:	☐ Portacath place / remove	
	☐ Other:		☐ Blood Transfusion	
			☐ Other:	

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