MONTANA HEALTH CENTERS | Operated by Premise Health

Blood Pressure Management Program Enrollment Form

Contact Information

Patient Name	Patient Birth Date (MM/DD/YY)
Provider Name (please print)	Provider Email*
Provider Telephone Number*	Provider Fax Number

**Please note: We use the contact information you provide to keep you updated on your patient's status. Please use your direct office line and email (as applicable).*

Referral Information

Number of Blood Pressure readings you'd like the patient to take per day:	
Specific times of day? Yes ☐ No ☐	If yes, when?
Notify Provider (Me) If:	Blood Pressure readings are above: Other:
Other notes:	

Consent

I am the patient's primary care provider and would like the patient to be enrolled in the Premise Health Blood Pressure Management Program. I understand the Blood Pressure Management Program is responsible for monitoring the patient's condition, not managing it. I understand that Premise Health will reach out to me regarding my patient's progress in the program.	
Provider Signature:	Date:

Return Form To:

Email: SM.CH.RemoteMonitoringMT@premisehealth.com
Fax: (406) 206-0304