2026 eCARE REFERRAL INTAKE FORM

Clear Spring Health

Referral Date:	Referring Provider (First Name, Last Name)	
Member Name:	Member DOB	Member ID:

PROVIDER DESIGNATION OF MEMBER VITAL SIGN PARAMETERS

Please let us know the expected parameters for your patient based on diagnosis and what actions to take when member reaches emergent parameters.

Weight Gain	☐ <2-3 lbs. in a 24-hr period ☐ <5 lbs. in a week ☐ Other:	Weight Frequency	☐ Daily ☐ Twice/wk. ☐ Three times/wk. ☐ Other:
Blood Pressure Systolic	☐ <120 mmHg ☐ Other: _____ mmHg	BP Frequency	☐ Daily ☐ Twice/wk. ☐ Three times/wk. ☐ Weekly ☐ Other:
Blood Pressure Diastolic	☐ <80 mmHg ☐ >5 lbs. in a week		
Oxygen Saturation (Sp02)	☐ <95% ☐ Other: _____	Sp02 Frequency:	☐ Daily ☐ Twice/wk. ☐ Three times/wk. ☐ Weekly ☐ Other:
Blood Glucose	☐ 70-180 mmHg ☐ Other: _____	Blood Glucose Frequency:	☐ Daily ☐ Twice/wk. ☐ Three times/wk. ☐ Weekly ☐ Other:

PROVIDER DESIGNATION - EMERGENT PARAMETERS

Blood Pressure	☐ >180/120 mmHg ☐ <90/60 mmHg ☐ Other: _____	Sp02 Frequency:	☐ Daily ☐ Twice/wk. ☐ Three times/wk. ☐ Weekly ☐ Other:
Blood Pressure	☐ >240 mm/dL ☐ <70 mm/dL ☐ Other: _____	Blood Glucose Frequency:	☐ Daily ☐ Twice/wk. ☐ Three times/wk. ☐ Weekly ☐ Other:

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ADDITIONAL PROVIDER ORDERS

If there are additional comments or concerns regarding this patient's care, please feel free to note them below:

Please share your office point of contact and the preferred method of receiving communications and alerts from us. You will be receiving a maximum of one report daily if any of your participating patients have out-of-range vital signs.

MODE OF COMMUNICATION

Point of Contact	
Phone	
E-mail	
Fax	

By signing this form, you are providing the eCare Home Monitoring Department staff with the vital sign parameters necessary to manage the care of your patient under the eCare Home Monitoring Program. These parameters would be taken as orders to ensure clear communication between the provider and the eCare staff.

Provider Signature	Date Signed

Please return completed form to the eCare Home Monitoring Department via fax at 781-207-0442 or via email at ecarehomemonitoring@clearspringhealthcare.com

SUBMIT

**Please Note - this form is able to be filled in, signed and securely submitted to Clear Spring Health. However, due to browser compatibility, that functionality is not available within pdf browser view. Please download the pdf to your local machine and then fill out to access submission functionality.*

MAIL
PO Box 3040
Spring Hill, FL 34611

PHONE
877-867-1351

EMAIL
ecarehomemonitoring@clearspringhealthcare.com