HOME HEALTH
RAPID REFERRAL FORM

Assured Home Health

P: 541.476.6224 | F: 541.476.2823

PATIENT INFORMATION REQUIRED TO START REFERRAL

Name: _____ DOB: _____

Gender: _____ Phone number: _____

OPTIONAL INFORMATION FOR COMPLETE REFERRAL

We can start the referral without this information, but it must be obtained before we visit the patient.

REASON FOR REFERRAL:

❑ Nursing: Medication management / education

❑ Nursing: Disease management / education

❑ Therapy: Therapeutic exercises

❑ PT ❑ OT ❑ ST

❑ Other: _____

Primary diagnosis: _____

Additional info that may be relevant: _____

_____

ADDITIONAL INFORMATION

We will call your office to obtain these documents if they are not attached to this referral.

- Last visit notes (face-to-face encounter)
- Demographic sheet
- History and physical
- Current medications / diagnoses list
- Primary health insurance information

PROVIDER SIGNATURE: _____ **DATE:** _____

PRINT NAME: _____

PHONE NUMBER: _____

Last updated May 2025