

# HOME HEALTH RAPID REFERRAL FORM



P: 541.773.1477 | F: 541.773.1559

## 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       Therapy: Therapeutic exercises

Nursing: Disease management / education       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:** \_\_\_\_\_