HOME HEALTH RAPID REFERRAL FORM

P: 503.561.5999 | F: 503.561.4905

PATIENT INFORMATION

Name ______________________________ DOB ______________

Primary Diagnosis with ICD Codes Preferred ______________________________

Comorbidities ______________________________

REASON FOR REFERRAL:

- ❑ Medication management / education
- ❑ Disease management / education
- ❑ Choose Control: Diabetes management program
- ❑ ClearWay: Chronic Lung Disease management program
- ❑ Respiratory Recovery at Home
- ❑ Therapeutic Exercises:
  - ❑ Total Therapy Balance
  - ❑ Total Therapy Ortho
  - ❑ Total Therapy Continence
  - ❑ Total Therapy Low Vision
  - ❑ Active Minds
- ❑ Other: ______________________________

DISCIPLINES NEEDED:

- ❑ Nursing
- ❑ Therapy

Notify provider of vital signs outside of the following patient specific parameters:

- ❑ O2 saturation < __________
- ❑ Systolic BP > __________ or < __________
- ❑ Diastolic BP > __________ or < __________
- ❑ HR > __________ or < __________
- ❑ Respirations > __________ or < __________
- ❑ Temperature > __________ or < __________

Was the patient in an inpatient facility within the last 14 days? ❑ No ❑ Yes

FAX WITH THIS FORM TO: 503.561.4905 WITH THE FOLLOWING:

- Last visit notes (face-to-face encounter)
- Demographic sheet
- History and physical
- Current medications / diagnoses list
- Health insurance card
- Wound care orders

PROVIDER SIGNATURE: ______________________________ **DATE:** ______________

PRINT NAME: ______________________________