

# HOME HEALTH RAPID REFERRAL FORM



**Assured  
Home Health**

P: 503.582.9246 | F: 503.685.9047

## 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 < \_\_\_\_\_
- ☐ HR > \_\_\_\_\_ or < \_\_\_\_\_
- ☐ Systolic BP > \_\_\_\_\_ or < \_\_\_\_\_
- ☐ Respirations > \_\_\_\_\_ or < \_\_\_\_\_
- ☐ Diastolic BP > \_\_\_\_\_ or < \_\_\_\_\_
- ☐ Temperature > \_\_\_\_\_ or < \_\_\_\_\_

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

## FAX WITH THIS FORM TO: 503.685.9047 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: \_\_\_\_\_