HOME HEALTH
RAPID REFERRAL FORM

At Home Healthcare

P: 303.369.7063 | F: 303.751.5401

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: 303.751.5401 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: _____