

HOME HEALTH RAPID REFERRAL FORM



P: 901.767.6767 | F: 901.415.3410

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: 901.415.3410 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: _____