

HOME HEALTH RAPID REFERRAL FORM



Capital Region
HOME HEALTH
Better. Every day.

P: 573.632.5750 | F: 573.632.5868

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: 573.632.5868 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: _____