

HOME HEALTH RAPID REFERRAL FORM

CAREtenders®

P: 502.933.2785 | F: 502.935.2057

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: 502.935.2057 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: _____