

RAPID REFERRAL FORM



P: 937.643.2422 • F: 937.643.2415

PATIENT INFORMATION

Name _____ DOB _____

Primary Diagnosis with ICD Codes Preferred _____

Comorbidities _____

In my opinion it is medically contraindicated for this patient to leave the home because the patient has:

___ suspected or confirmed diagnosis of COVID-19; or

___ patient has a condition that may make the patient more susceptible to contracting COVID-19; and

___ I authorize the use of telehealth and telecommunications as necessary and appropriate for this patient's treatment

REASON FOR REFERRAL

Check Services Required

☐ Wound Care/Negative Pressure Wound Therapy

☐ Medication Management for _____

☐ Disease Management Instruction for _____

☐ Therapeutic Exercises

☐ Other: _____

Was the patient in an inpatient facility within the last 14 days?

☐ No

☐ Yes

FAX WITH THIS FORM TO: 937.643.2415 WITH THE FOLLOWING:

___ Most Recent Exam Notes ___ Current Medication List ___ Demographic Sheet ___ Insurance Card

PHYSICIAN SIGNATURE: _____ **DATE:** _____