

HOME HEALTH RAPID REFERRAL FORM



P: 270.885.6353 | F: 270.885.2410

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:

<input type="checkbox"/> O2 saturation < _____	<input type="checkbox"/> HR > _____ or < _____
<input type="checkbox"/> Systolic BP > _____ or < _____	<input type="checkbox"/> Respirations > _____ or < _____
<input type="checkbox"/> Diastolic BP > _____ or < _____	<input type="checkbox"/> Temperature > _____ or < _____

Was the patient in an inpatient facility within the last 14 days? No Yes

FAX WITH THIS FORM TO: 270.885.2410 WITH THE FOLLOWING:

<ul style="list-style-type: none">• Last visit notes (face-to-face encounter)• Demographic sheet• History and physical	<ul style="list-style-type: none">• Current medications / diagnoses list• Health insurance card• Wound care orders
--	--

PROVIDER SIGNATURE: _____ DATE: _____

PRINT NAME: _____