HOME HEALTH
RAPID REFERRAL FORM

LHC - Illinois
Home Health Care
Phone: 844.863.0111 | Fax: 844.863.0222

PATIENT INFORMATION

Name _____ DOB _____

Primary Diagnosis with ICD Codes Preferred _____

Comorbidities _____

REASON FOR REFERRAL

❑ Medication management / education
❑ Disease management / education
❑ Respiratory Recovery at Home
❑ Choose Control: Diabetes management program
❑ Therapeutic Exercises:
❑ Active Life Balance ❑ Active Minds ❑ Continence Control ❑ Customized Ortho ❑ Low Vision
❑ Other: _____

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: 844.863.0222 with the following:

___ Most recent exam notes ___ Current medication list ___ Demographic sheet ___ Health insurance card
___ Wound care orders

PROVIDER SIGNATURE: _____ **DATE:** _____

PLEASE PRINT NAME: _____