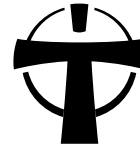


# HOME HEALTH RAPID REFERRAL FORM



ST. FRANCIS  
MEDICAL CENTER  
HOME HEALTH

P: 318.327.4500 | F: 318.410.8879

## 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  
Continenace

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: 318.410.8879 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: \_\_\_\_\_