

HOME HEALTH RAPID REFERRAL FORM



P: 865.337.7859 | F: 865.454.8097

PATIENT INFORMATION REQUIRED TO START REFERRAL

Name: _____ DOB: _____

Gender: _____ Phone number: _____

OPTIONAL INFORMATION FOR COMPLETE REFERRAL

We can start the referral without this information, but it must be obtained before we visit the patient.

REASON FOR REFERRAL:

Nursing: Medication management / education Therapy: Therapeutic exercises

Nursing: Disease management / education PT OT ST

Other: _____

Primary diagnosis: _____

Additional info that may be relevant: _____

ADDITIONAL INFORMATION

We will call your office to obtain these documents if they are not attached to this referral.

- Last visit notes (face-to-face encounter)
- Demographic sheet
- History and physical
- Current medications / diagnoses list
- Primary health insurance information

PROVIDER SIGNATURE: _____ **DATE:** _____

PRINT NAME: _____

PHONE NUMBER: _____