

# HOME HEALTH RAPID REFERRAL FORM



P: 706.729.6000 | F: 706.729.6094

## 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: 706.729.6094 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: \_\_\_\_\_