

# HOME HEALTH RAPID REFERRAL FORM



P: 478.552.0966 | F: 478.552.0969

## 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: 478.552.0969 WITH THE FOLLOWING:

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

PRINT NAME: \_\_\_\_\_