

## Rapid Referral Form

Please fax to (866) 571-9365

**To: Intake** \_\_\_\_\_ **From:** \_\_\_\_\_  
**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient Demographic Information** Info Attached:  Yes  No (Complete The Following)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
Gender:  Male  Female DOB (mm/dd/yyyy): \_\_\_\_\_ SS #: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Street: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Benefits Information:**

Medicare #: \_\_\_\_\_ Medicaid #: \_\_\_\_\_  
Insurance: \_\_\_\_\_ Insurance #: \_\_\_\_\_ Phone: \_\_\_\_\_

**Physicians Orders** Order Attached:  Yes  No (Complete The Following)

Physician Name: \_\_\_\_\_ Encounter Date: \_\_\_\_\_

Encounter findings that confirm need for Home Health Care: ICD10# \_\_\_\_\_

Homebound Reason: \_\_\_\_\_

Check Required Services: Please add a brief reason for ordered discipline such as "eval & treat"

RN: \_\_\_\_\_

PT: \_\_\_\_\_

HHA: \_\_\_\_\_

Other: \_\_\_\_\_

Patient Requires Assistive Device?  Yes  No (Circle All That Apply)  
Walker      Wheelchair      Cane      Hands on Assist      Stand by Assist

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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