RAPID REFERRAL FORM

ATMORE
COMMUNITY HOME CARE

P: 251.368.6286 • F: 251.368.6289

PATIENT INFORMATION

Name _____ DOB _____

Primary Diagnosis with ICD Codes Preferred _____

Comorbidities _____

In my opinion it is medically contraindicated for this patient to leave the home because the patient has:

___ suspected or confirmed diagnosis of COVID-19; or

___ patient has a condition that may make the patient more susceptible to contracting COVID-19; and

___ I authorize the use of telehealth and telecommunications as necessary and appropriate for this patient's treatment

REASON FOR REFERRAL

Check Services Required

❑ Wound Care/Negative Pressure Wound Therapy

❑ Medication Management for _____

❑ Disease Management Instruction for _____

❑ Therapeutic Exercises

❑ Other: _____

Was the patient in an inpatient facility within the last 14 days?

❑ No ❑ Yes

FAX WITH THIS FORM TO: 251.368.6289 WITH THE FOLLOWING:

___ Most Recent Exam Notes ___ Current Medication List ___ Demographic Sheet ___ Insurance Card

PHYSICIAN SIGNATURE: _____ **DATE:** _____

Last updated 4.6.20