RAPID REFERRAL FORM

CAPE FEAR VALLEY
HOME HEALTH

P: 910.609.6740 • F: 910.609.6573

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: 910.609.6573 WITH THE FOLLOWING:

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

PHYSICIAN SIGNATURE: ______________________________ **DATE:** ______________

Last updated 4.6.20