RAPID REFERRAL FORM

Capital Region HOME HEALTH

P: 573.632.5750 • F: 573.632.5868

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: 573.632.5868 WITH THE FOLLOWING:

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

PHYSICIAN SIGNATURE: _____ **DATE:** _____