

# RAPID REFERRAL FORM

## 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: 570.520.4214 WITH THE FOLLOWING:

\_\_\_ Most Recent Exam Notes    \_\_\_ Current Medication List    \_\_\_ Demographic Sheet    \_\_\_ Insurance Card

PHYSICIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_