

RAPID REFERRAL FORM

Community Home Health™

P: 904.810.5474 • F: 904.826.0224

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: 904.826.0224 WITH THE FOLLOWING:

___ Most Recent Exam Notes

___ Current Medication List

___ Demographic Sheet

___ Insurance Card

PHYSICIAN SIGNATURE: _____ **DATE:** _____