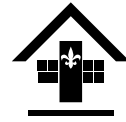


# RAPID REFERRAL FORM



LHC - Illinois  
Home Health Care

P: 217.352.4387 • F: 217.352.2505

## 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: 217.352.2505 WITH THE FOLLOWING:**

\_\_\_ Most Recent Exam Notes

\_\_\_ Current Medication List

\_\_\_ Demographic Sheet

\_\_\_ Insurance Card

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