

RAPID REFERRAL FORM

Regional Home Care

P: 870.816.3500 • F: 870.338.9321

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: 870.338.9321 WITH THE FOLLOWING:

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

PHYSICIAN SIGNATURE: _____ DATE: _____