

# RAPID REFERRAL FORM



HOME CARE SERVICES

P: 865.475.6930 • F: 865.475.5620

## 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: 865.475.5620 WITH THE FOLLOWING:**

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

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