RAPID REFERRAL FORM

Phone: 330.779.3389 | Fax: 330.779.3395

PATIENT INFORMATION

Name ______________________________ DOB ______________

Primary Diagnosis with ICD Codes Preferred ______________________________

Comorbidities ______________________________

REASON FOR REFERRAL

Check Services Required

- ☐ Assessment/Teaching for ______________
- ☐ Wound Care/Negative Pressure Wound Therapy
- ☐ Medication Management for ______________
- ☐ Disease Management Instruction for ______________
- ☐ Therapeutic Exercises
- ☐ Gait Training
- ☐ Continence Control/Pelvic Floor Program
- ☐ Other: ______________

Was the patient in an inpatient facility within the last 14 days?

☐ No ☐ Yes; select below

- ____ Skilled Nursing Facility
- ____ Hospital
- ____ Inpatient Rehabilitation Facility
- ____ Inpatient Psychiatric Hospital
- ____ Long-Term Care Hospital

Ohio's Choice
HOME HEALTH

ROSS MILICIA
Account Executive

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Patient Specific Parameters: Use the following patient specific parameters to notify the physician of patient changes:

Blood Pressure (>______/______<) Pulse (>______/______<) Respiratory (>______/______<)

Temperature (>______/______<) 02 Saturation (>______/______<) Complete Blood Glucose (>______/______<)

Proactive orders for weight shift of (+) ______ or (-) ______ pounds: ______________________________

FAX WITH THIS FORM TO: 330.779.3395 With The Following:

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

PHYSICIAN SIGNATURE: ______________________________ **DATE:** ______________