



# RAPID REFERRAL

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## REFERRAL INFORMATION FAX: (888) 553-7575 OR (254) 778-7010

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ Patient Phone: \_\_\_\_\_  
\_\_\_\_\_ Alternate Phone (Cell): \_\_\_\_\_  
Alternate Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell: \_\_\_\_\_  
Social Security #: \_\_\_\_\_  
Insurance Carrier Name: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Medicare #: \_\_\_\_\_  
Services/ Programs: \_\_\_\_\_ Evaluate & Treat \_\_\_\_\_ SN \_\_\_\_\_ PT \_\_\_\_\_ OT \_\_\_\_\_ ST \_\_\_\_\_ MS \_\_\_\_\_ HHA  
\_\_\_\_\_ Wound Care \_\_\_\_\_ PT/INR \_\_\_\_\_ TKA/THA \_\_\_\_\_ IV Therapy  
Physician Orders/Instructions (Please include specific wound care & IV orders if applicable):  
\_\_\_\_\_  
\_\_\_\_\_

**Physician's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## FACE-TO-FACE DOCUMENTATION

I certify that this patient is under my care and that I, a nurse practitioner, clinical nurse specialist, or physician's assistant working with me, had a face-to-face encounter that meets the Medicare physician face-to-face encounter requirements.

**Date of Face-to-Face:** \_\_\_\_\_

The encounter with the patient was related to the following medical condition(s), which is the primary reason for home healthcare:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I certify that based on my findings, the following services are medically necessary home health services (Check all that apply):  
\_\_\_\_\_ SN \_\_\_\_\_ PT \_\_\_\_\_ OT \_\_\_\_\_ ST or Other: \_\_\_\_\_

Clinical findings that support the need for home health: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I certify in the Narrative below that my clinical findings support that this patient is home bound because (i.e., absences from home require considerable and taxing effort, are infrequent or of short duration, or are attributable to the need to receive health care):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Physician's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Physician's Printed Name:** \_\_\_\_\_

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