MOUNTAIN HOME HEALTH

# RAPID REFERRAL FORM- BLAIRSVILLE, GA

| REFERRAL INFORMATION | Today's Date: |
|---|---|
| Referring Name: | Referring Phone Number: |
| Requested Start of Care Date: | *If no SOC date noted, care provided within 48 hrs.* |
| Physician Name: | NPI#: |
| Physician Phone Number: | |
| Facility Name: | Facility Contact: |
| **PATIENT INFORMATION** | |
| Patient Name: | SSN: |
| Date of Birth (mm/dd/yyyy): | Phone: |
| Address: | City, State, Zip: |
| CG/Alternate Contact Name: | Primary Care Physician: |
| CG/Alternate Contact Phone: | Office Phone: |
| **INSURANCE INFORMATION** | |
| Patient Medicare #: | Insurance ID: |
| Insurance Carrier: | Policy Holder Name: |
| Policy Holder DOB: | |
| **PRIMARY DIAGNOSIS/MEDICAL CONDITION REQUIRING HOME HEALTH:** | **OTHER RELEVANT DIAGNOSIS:** |
| | |
| **PHYSICIAN ORDERS** | |
| □ Skilled Nursing for: | □ Physical Therapy for: |
| □ Occupational Therapy for: | □ Speech Therapy for: |
| □ Social Work for: | □ Home Health Aide for: |
| Other: | |
| ***I certify that this patient is under my care and that I, or a nurse practitioner or Physician Assistant working with me or a physician who cared for the patient in an acute or post-acute facility has a face-to-face encounter related to the primary reason that patient requires home health*** | |
| **Face to Face Date:** | **Date of last office visit:** |
| **Physician Signature:** | **Date:** |

## *Fax this completed form <u>with the following</u> to Mountain Home Health*

## 706.745.5139

| □ Most Recent Exam Note | □ Medication List | □ Demographic Sheet |
|---|---|---|

| □ Acute/Post-acute H&P / DC Summary | Acute/Post-acute facility Name: |
|---|---|
| DC Date: | |

**"We Strive for Excellence"**