A copy of this form can be downloaded from our website at **www.goodlifehomecare.com/contact_us.html**

QUICK-FAX HOME HEALTH REFERRAL FORM

FROM: (*YOUR NAME/ORGANIZATION*):_____

1) FIRST, PLEASE FAX THIS FORM TO: **(831) 646-8246**

To expedite this referral, please send the following with this form:
- *Face sheet, H&P, Current Medication List, Copy of Insurance Cards*

2) THEN, CALL US TO CONFIRM RECEIPT: **(831) 646-2046**

Please check services required by patient:

☐ **SKILLED NURSING** – Registered Nurse will do full medical assessment and contact physician with findings, S/S of complications, recommendations and approval for Plan of Care.

- ☐ Pain Management
- ☐ Medication Instruction and Administration
- ☐ Wound Care Specialist
- ☐ Safety, Emergency and Disease Management Education
- ☐ Labs
- ☐ Other: _____

☐ **PHYSICAL THERAPY** – Evaluation and Treatment resulting from:

- ☐ Surgery: _____/_____/_____
- ☐ Fall Prevention/Recovery
- ☐ Gait/Mobility Training
- ☐ TherEx/HEP Strengthening
- ☐ Home Safety Evaluation
- ☐ Other: _____

☐ **SECONDARY SERVICES** – Check all that apply:

- ☐ Occupational Therapy (OT) -- For activities of daily living
- ☐ Speech Therapy (ST) -- For communication/cognition/swallowing
- ☐ Home Health Aid (HHA) -- For personal care
- ☐ Medical Social Worker (MSW) -- For long-term planning, community resources, advanced directives
- ☐ Registered Dietitian – For nutritional guidance

☐ **PRIVATE DUTY COMPANION (CAREGIVER)** – Assistance with personal care, cooking, housekeeping and ADL.

PATIENT INFORMATION

Demographics Sheet Attached? ☐ **YES,** if not complete info below:

PATIENT FULL NAME:

_____

STREET/APT:

_____

CITY/STATE/ZIP:

_____

PHONE NUMBER(S):

_____

DOB: _____/_____/_____ **GENDER:** ☐ MALE ☐ FEMALE

PATIENT CURRENTLY RESIDES: ☐ Home ☐ Hospital ☐ SNF ☐ AL ☐ RCFE

DISCHARGED FROM: _____ **DATE:** _____/_____/_____

PHYSICIAN INFORMATION

The following is the physician who will authorize home health care services and follow this patient:

PHYSICIAN NAME:

_____

PHYSICIAN PHONE & FAX:

(P)_____(F)_____

PHYSICIAN SIGNATURE:

_____

REFERRAL DATE: _____

OFFICE CONTACT:

_____

OFFICE CONTACT TITLE:

_____