RAPID REFERRAL FORM

Providence HOME HEALTH

Phone: 803.343.5100 | Fax: 803.758.4001

PATIENT INFORMATION

Name _____ DOB _____

Primary Diagnosis _____

PHYSICIAN ORDERS

Check Services Required

Skilled Nursing

___Evaluation
___Assessment/Teaching
___Labs (with skilled service)
_____
___Wound Care/Negative Pressure Wound Therapy
___Medication Management
___Disease Management Instruction
___Other_____

Physical Therapy

___Evaluation/Treat
___Therapeutic Exercises
___Gait Training
___Endurance and Strengthening
___Continence Control/Pelvic Floor Program
___Other_____

Speech Therapy

___Evaluation/Treat
___Oromuscular re-education
___Aspiration precautions
___Augmentative Communication Device
___Alternate Communication Plan
___Speech Intelligibility Exercises
___Cognitive Skills Training: memory/sequencing/orientation
___Other_____

Occupational Therapy

___Evaluate/Treat
___Hand therapy/Upper Extremity
___ADL Re-training/Home Management Safety
___Adaptive Equipment Recommendation
___Low Vision
___Continence Control/Pelvic Floor Program
___Other_____

Other

___Evaluate patient for LHC PERS(Personal Emergency Response System)Unit

Social Worker

___Assess safety/living situation
___Assess community resource needs
___Other_____

Home Health Aide

___Personal Care
___Other_____

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

BP(>/<)_____ Pulse(>/<)_____ Resp(>/<)_____ Temp(>/<)_____ 02 SAT(>/<)_____ Weight(+/-)_____

Date Vaccine Administered:

Vaccination History: Flu_____ Tetanus_____ Pneumonia_____ Shingles_____ Other_____

_____

Other: _____

_____

FAX WITH THIS FORM TO: 803-758-4001 With The Following:

_____Most recent exam notes _____Current medication list _____Demographic sheet

PHYSICIAN SIGNATURE: _____ **DATE:** _____