



## FAX REFERRAL TO 620.341.9375

To	<b>INTAKE TEAM</b>	Person Sending Referral
Phone	620.341.9350	Fax #
Fax	620.341.9375	Phone

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

Diagnosis/Skilled Need \_\_\_\_\_ Insurance \_\_\_\_\_

### Orders—

- Home Health** Check all that apply
- |                                      |   |   |   |
|--------------------------------------|---|---|---|
| <input type="checkbox"/> Nursing     | <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Speech Therapy |
| <input type="checkbox"/> Social Work | <input type="checkbox"/> Home Health Aide | <input type="checkbox"/> Infusion             | <input type="checkbox"/> Dietitian      |



**Help At Home**

Please fax the following documents with this referral

- Demographic/Face Sheet     Medication list     History & Physical     MD visit note (most recent)

Comments or Special Instructions

**Needs Identified:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Medication Management/Safety (RN)     | <input type="checkbox"/> Strength/Mobility (PT) | <input type="checkbox"/> Home Safety Assessment (OT) |
| <input type="checkbox"/> For Long Term Planning/Placement (SW) | <input type="checkbox"/> Other _____            |  |

Physician Name \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Direct further orders to (PCP) \_\_\_\_\_ MD to sign F2F \_\_\_\_\_

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