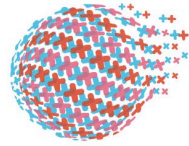


RAPID REFERRAL FORM



UNITED AMERICA +
HOME HEALTH

PATIENT INFORMATION

Name _____ DOB _____

Primary Diagnosis with ICD Codes Preferred _____

Comorbidities _____

REASON FOR REFERRAL

Check Services Required

Wound Care/Negative Pressure Wound Therapy

Medication Management for _____

Disease Management Instruction for

Therapeutic Exercises

Other: _____

Was the patient in an inpatient facility within the last 14 days?

No

Yes

FAX WITH THIS FORM TO: 713-975-7312 WITH THE FOLLOWING:

____ Most Recent Exam Notes

____ Current Medication List

____ Demographic Sheet

____ Insurance Card

PHYSICIAN SIGNATURE: _____ **DATE:** _____