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:** _____