PERIMETER HOME HEALTH
P: 757-935-5300 | F: 1-833-761-1119

Rapid Referral Form

Please Send the Referral to
intake@perimeterhh.com
or Fax: 1-833-761-1119

Patient Name: _____ Date of Birth: _____

Diagnosis/ICD-10 Codes:

_____ _____
(primary reason for home health)

_____ _____

Orders:

[ ] Skilled Nursing [ ] Physical Therapy [ ] Speech Therapy

note: the following disciplines below may only be ordered if one of the disciplines above has been selected

[ ] Occupational Therapy [ ] Medical Social Work [ ] Home Health Aide

Reason for Ordered Services:

[ ] Medication Management [ ] Swallowing [ ] Pain Management
[ ] Disease Management [ ] Cognition [ ] Diabetic Management
[ ] Ambulation/Gait Training [ ] Assist with ADLs [ ] IV
[ ] Surgical Aftercare following [ ] Hip [ ] Knee [ ] Shoulder Replacement per protocol
[ ] Wound Care (please describe):

_____

_____

Additional Notes: _____

Was the patient admitted to a hospital or skilled nursing facility within the last 14 days? [ ] Yes [ ] No

To expedite this referral, please send over the following documents along with this sheet:

___ Patient Demographics (including address, phone, and insurance information)

___ Most Recent Office Visit Note and/or Discharge Summary from inpatient facility

___ Medication List

By signing below, I authorize Perimeter Home Health to evaluate and treat the patient for skilled home health care services.

Physician/NP/PA Signature: _____ Date: _____

Physician/NP/PA Name: _____

If need more info, please contact _____ at Phone: _____
(referral source)