Randolph Health Home Health

Home Health Fast Fax Referral Form

(Please fill in as completely as possible)

FAX (336) 625-2209
Questions? Need Assistance?
Call our
Intake Coordinator
PHONE (336) 633-7721

Referral Contact: _____ **Phone:** _____**Date:** _____

Referring Physician/PA-C/NP: _____

Insurance Provider: _____ Policy #: _____ Group #: _____

_____ ___/___/_____ ___-___-____ _____ _____
Last Name First M.I. Date of Birth S.S.# Sex Race

_____ (_____)_____-_____
Street Address (Physical address – **NO PO BOXES PLEASE!**) Phone (**To contact for scheduling**)

_____ _____ (_____)_____-_____
City Zip Code Alternate Phone

_____ _____ (_____)_____-_____ (_____)_____-_____
Emergency Contact Relationship to Patient Phone Contact Alternate Phone

May attach demographic sheet in lieu of completing this section.

Primary Diagnosis/ICD-10 Code that requires home health: _____

Significant co morbidities: _____

Has patient recently been hospitalized or discharged from a Skilled Nursing Facility? Yes/No

Inpatient location: _____ Discharge date: _____

Disciplines Requested: **SN PT OT ST Social Worker Bath Aide**
(Select all that apply)

Program/Skill Requested: **Nursing:** **___Heart Failure/COPD** **PT: ___Life Balanced**
___Wound Care **___Maintenance Therapy**
___IV Therapy
___Antibiotic Injection **ST: ___Memory Care**

Please include the following with this fax:
___Current list of medications
___Last visit note (Must reflect home health need)
___Most recent HgbA1c result (if applicable)
___Specific wound care order (if applicable)
___Specific antibiotic administration order (if applicable)

Thank You
For choosing us to provide high quality healthcare to OUR community!