



FAST TRACK REFERRAL FORM

Insurance may request medical records from Physicians. Please retain supporting documentation such as d/c summary, labs, last office visit note and medication profile in your medical record.

Please complete and fax the following information (or attach demographics / face sheet) and office visit note to: (815) 651-1766.

PATIENT	Patient Name: _____	SSN: _____
	Date of Birth: _____ <input type="checkbox"/> M <input type="checkbox"/> F	Address: _____
	Phone: _____	City, State, Zip: _____
	Alternate Contact Name: _____	Last Flu Vaccine Date: _____
	Alternate Contact's Number: _____	Referral Date: _____
	Primary Care Physician: _____	Insurance Information: _____ <i>(or attach copy)</i>
Office Contact Name: _____		Office Contact Number: _____

DIAGNOSIS / MEDICAL CONDITION: *(List the diagnosis / medical conditions that are the primary reason the patient requires home health care.)*

HgbA1C Date: _____ HgbA1C Result: _____

SKILLED SERVICES / INTERVENTIONS: *(The nurse or therapist will perform in the home, e.g. assess, teach, wound care, gait training.)*

- Home Health Aide: _____
- Social Work: _____
- Physical Therapy for: _____
- Occupational Therapy: _____
- Speech Therapy for: _____

ADDITIONAL ORDERS: _____

Face-to-Face Encounter Date _____ / _____ / _____

Based on the above findings, I certify that this patient is eligible for home health service. The patient is under my care and I have initiated the establishment of the plan of care for home health.

Physician's Printed Name: _____

Physician Signature: _____ Signature Date: _____

OPTIONAL PHYSICIAN DOCUMENTATION
This section is provided for the physician's convenience and record keeping in the event of an audit.

CLINICAL FINDINGS: *(Signs and symptoms of medical condition exhibited by the patient during the encounter that support the need for all services listed above.)*

HOMEBOUND STATUS: *(Describe the clinical and / or physical findings and the functional limitations that result in the patient's normal inability to leave home.)*

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