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: _____ ☐ M ☐ F Address: _____

Phone: _____ City, State, Zip: _____

Alternate Contact Name: _____ Last Flu Vaccine Date: _____

Alternate Contact's Number: _____ Referral Date: _____

Primary Care Physician: _____ Insurance Information: _____
(or attach copy)

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.)*