# Home Health Referral Form

**FAX: 281-822-3083**

Please fax this completed form along with a physician Rx and associated progress notes to. Lack of clinical information may result in delayed processing. *Indicates Required Field

| **PATIENT INFORMATION** | | | | | |
|---|---|---|---|---|---|
| First Name: | Last Name: | | M.I. | Phone: | |
| Address: | | City: | | State: | Zip: |
| DOB: | Gender: | Ht: | Wt: | Social Security #: | |
| Emergency Contact/Resp Party: | | | | Phone: | |
| Address: | | Email: | | | |

| **INSURANCE INFORMATION** | |
|---|---|
| Primary Ins: ☐ Medicare ☐ Medi-Cal ☐ Other | Secondary Ins: ☐ Medicare ☐ Medi-Cal ☐ Other |
| Name: | Name: |
| Member ID #: | Member ID #: |

| **DIAGNOSES / ICD-10 CODES** | | | |
|---|---|---|---|
| Dx 1: | Dx 2: | Dx 3: | Dx 4: |

| **Home Health Services** | | |
|---|---|---|
| ☐ **RN** | ☐ **PT** | ☐ **OT** |
| ☐ **ST** | ☐ **MSW** | ☐ **Wound Care** |
| ☐ **Other** | | |

| **PHYSICIAN INFORMATION** | | | |
|---|---|---|---|
| Name: | NPI#: | | |
| Address: | City: | State: | Zip: |
| Referral Contact: | Phone: | Fax: | |

**Physician Signature: _____**

**Date: _____**

**PLEASE FAX Rx w/ICD-10 CODES & PROGRESS NOTES ALONG WITH THIS REFERRAL FORM TO FAX NUMBER ABOVE**