

Referral Date:	Faxed By:	Phone:
Referring Physician:		Extension:

EXPRESS HOME HEALTH REFERRAL

Patient Last Name:	First Name:	
Address:		
City:	Zip Code:	Phone:
SSN:	DOB:	
Allergies:		
Primary Insurance:	<input type="checkbox"/> Medicare Number:	<input type="checkbox"/> Medi-Cal Number:
	<input type="checkbox"/> Other	
Primary Physician:	Phone:	
Is caregiver willing and able to learn and provide patient care? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Family Contact:	Phone:	
Caregiver Name:	Phone:	

Skilled Nurse Evaluation	Physical & Occupational Therapy Evaluation	Speech Therapy Evaluation
<input type="checkbox"/> New Diagnosis <input type="checkbox"/> Wound Care <input type="checkbox"/> Disease Process Education <input type="checkbox"/> Diabetic Education /Medication Management <input type="checkbox"/> Other _____	<input type="checkbox"/> New Fracture <input type="checkbox"/> Frequent Falls <input type="checkbox"/> Transfer/Gait Training <input type="checkbox"/> New Generalized Weakness <input type="checkbox"/> Other _____	<input type="checkbox"/> Energy Conservation <input type="checkbox"/> New Decline in Daily Living Activities <input type="checkbox"/> Joint Protection Techniques/ Adaptive Equipment <input type="checkbox"/> Dysphagia <input type="checkbox"/> Dysphasia <input type="checkbox"/> Impaired Cognition <input type="checkbox"/> Other _____

Written Orders (This section must be completed to process the referral)

IV Orders:	Special Instructions:
I certify/recertify this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized the services on this initial order and will periodically review the plan of care.	
Physician's Signature: _____	NPI#: _____

PLEASE FAX HISTORY AND PHYSICAL AS SOON AS POSSIBLE