HEALTHCARE CALIFORNIA
Home Health Agency

FAX TO _____
HealthCare California
ATTN: Intake Department
Fax: (559) 243-9994
Tel: (559) 243-9990

RAPID FAX REFERRAL

REFERRAL FROM

Provider _____ Sent by _____ Date _____

Total # of pages _____ Tel _____ Fax _____

Patient Name _____ DOB _____

Please start services on date _____

Diagnosis _____

The Following Is Needed To Process A Referral

☐ Face Sheet *(required)*

☐ History & Physical and/or Progress Note *(if applicable)*

☐ Copies of Insurance Card *(required)*

☐ Face to Face form *(see below)*

Face to Face is a Medicare required document that must accompany any new Medicare patient referral. Please contact our Intake Department if you need help completing this form.

HOME HEALTH SKILLED SERVICES

☐ Skilled Nursing
☐ Physical Therapy
☐ Occupational Therapy
☐ Speech Therapy
☐ IV Therapy
☐ Home Safety Evaluation
☐ Ostomy Care
☐ Diabetic Care
☐ Social Services
☐ Nurse Wound Evaluation
☐ Negative Pressure Wound Therapy
☐ G-tube Feedings
☐ Home Health Aide

IV Dosage _____ ☐ Injections _____

☐ Medical Equipment _____

Provider Instructions _____

_____

_____

Provider's Signature _____ **Date** _____