BRIDGEWAY
HOME HEALTH

RAPID REFERRAL FORM

REFERRAL INFORMATION	Today's Date**:**
Referring Name:	Referring Phone Number:
Requested Start of Care Date:	*If no SOC date noted, care provided within 48 hrs.*
Physician Name:	NPI#:
Physician Phone Number:	
Facility Name:	Facility Contact:
PATIENT INFORMATION	
Patient Name:	SSN:
Date of Birth (mm/dd/yyyy)**:**	Phone:
Address:	City, State, Zip:
CG/Alternate Contact Name:	Primary Care Physician:
CG/Alternate Contact Phone:	Office Phone:
INSURANCE INFORMATION	
Patient Medicare #:	Insurance ID:
Insurance Carrier:	Policy Holder Name:
Policy Holder DOB:	
Primary Diagnosis/Medical Condition requiring Home Health:	**Other Relevant Diagnosis:**
PHYSICIAN ORDERS	
□ Skilled Nursing for:	□ Physical Therapy for:
□ Occupational Therapy for:	□ Speech Therapy for:
□ Social Work for:	□ Home Health Aide for:
Other:	
I certify that this patient is under my care and that I, or a nurse practitioner or Physician Assistant working with me or a physician who cared for the patient in an acute or post-acute facility has a face-to-face encounter related to the primary reason that patient requires home health	
Face to Face Date:	**Date of last office visit:**
Physician Signature:	**Date:**

Fax this completed form <u>with the following</u> to BridgeWay Home Health

678.806.5350

□ Most Recent Exam Note	□ Medication List	□ Demographic Sheet

□ Acute/Post-acute H&P / DC Summary	Acute/Post-acute facility Name:
DC Date:	

"We Strive for Excellence"