Referral Form

Please fax this form along with required documentation
To Fax# **305-418-9378 or 1-855-481-0606**

☐ **Expedited**
(Requires Physician Signature)

X ______________________

Policy Number:	Patient Last Name:	Patient First Name:
Health Plan:	Date of Birth:	Phone Number:
Service address:		

Sender's Name OR Company Name and Number:	Discharge Facility:	Discharge Date:

Diagnosis- ICD-10 Codes

S.O.C

	Requested start date of service:

Services Requested

☐ Home Health Orders (If HH is not ordered By MD or DO must be countersigned by the attending physician)

☐ **Nurse Evaluation** –for home or wound care needs & treatment ______________________________________

Wound care treatment plan & Location: ____

____

☐ **Physical Therapy Evaluation** & Treatment ☐ **O.T Evaluation** ☐ **S.T Evaluation**

☐ **Home infusion**/ Medication Administration, Medication, dosage, route & frequency/ duration:

____

☐ **Other**:

☐ Durable Medical Equipment and Supplies (Power Mobility devices orders must include a Physical Therapist evaluation)

Please describe

____ Height: _______

____ Weight:_______

☐ **Oxygen Therapy:**

- O2 Saturation Level on Room Air _________%
- Date O2 Sat was taken: _________________
- Taken @ rest or with ambulation: _______________
- If taken with ambulation- resting O2 Sat: _________%
- Bled into CPAP/BIPAP : Yes ________ No_________

Script needs to have dx, settings (liters per minute, route of administration, continuous or nocturnal) AND oxygen saturation on room air.

☐ **CPAP Therapy:** ______Initial

☐ **BIPAP Therapy:** ______ Extension of existing rental

Date of SOC _______________

- Settings _____________________
- Baseline AHI __________________

For PAP Rental extension please provide PAP Compliance Report.
For Initial PAP Rental please attach baseline sleep study report.
For Bipap therapy, please provide two (2) pressure settings.

Ordering Physician Information (If no Dr's signature, must attach signed Rx)

Name of Ordering physician:	NPI #	Date:
Signature	Phone:	Fax:

*****Attach any clinical notes, H&P, discharge orders, labs, and imaging reports to support medical necessity*****