Texas Home Health Group
an AccentCare® Company
a home healthcare affiliation with Baylor Scott & White

# HOME HEALTH
# REFERRAL / ORDER FORM

## Phone: (844) 440-4321 Intake Fax: (844) 333-0632

***Please complete this form in its entirety and fax to the Intake Fax number listed above.***

| Patient Contact Information | | | |
|---|---|---|---|
| **Last Name:** | **First Name:** | **Middle Initial:** | **Sex:** |
| **Date of Birth:** | | **Medicare ID #:** | |
| **Street Address:** | | **Apt #:** | |
| **City:** | **State:** | **Zip Code:** | |
| **Home Phone:** | | **Cell Phone:** | |
| **Emergency Contact:** | | **Phone:** | |
| **Power of Attorney:** | | **Phone:** | |

| Patient Insurance Information | | |
|---|---|---|
| **Primary Insurance:** | | |
| **Name of Insurance:** | **Policy #:** | **Group #:** |
| **Patient's Relationship to Policy Holder:** | | |
| **Secondary Insurance:** | | |
| **Name of Insurance:** | **Policy #:** | **Group #:** |
| **Patient's Relationship to Policy Holder:** | | |

## Referral Information

**Primary Diagnosis** (including medical conditions):

**Secondary Diagnoses** (please list all that apply):

**Evaluate and Treat** (check all that apply): ☐ SN ☐ PT ☐ OT ☐ ST ☐ BHN ☐ MSW

**Additional Orders:** ☐ Face-to-face

**Recent Hospitalization:** ☐ Yes Date(s): _____
☐ No

**RightPath® Program(s) to include in patient's treatment plan:**

☐ COPD ☐ Cardiac Care ☐ Diabetes Care ☐ Joint Rehabilitation ☐ Late Life Depression/Dementia Care/Behavioral Health ☐ Palliative Care

**Additional information included with this faxed form** (please send all available):

☐ History/Physical ☐ Progress notes (3 month) ☐ Medication list ☐ Lab report(s)

| | | |
|---|---|---|
| **Referring Physician/Provider Signature:** | **Date signed:** | **Phone:** |
| **Facility:** | | **Phone:** |
| **Primary Care or Following Physician:** | | **Phone:** |
| **Account Executive Name:** | | **Phone:** |