REFERRAL FORM

Pathways Healthcare

PATIENT INFORMATION

Name: _____ DOB: _____

INSURANCE (NOT NEEDED IF PROVIDING INSURANCE CARD): _____

Primary Diagnosis with ICD Codes Preferred: _____

Comorbidities: _____

In my opinion it is medically contraindicated for this patient to leave the home because the patient has:

_____ suspected or confirmed diagnosis of COVID-19; or

_____ patient has a condition that may make the patient more susceptible to contacting COVID-19; and

_____ I authorize the use of telehealth and telecommunications as necessary and appropriate for this patient's treatment

REASON FOR REFERRAL

Check Services Required

- ☐ Wound Care
- ☐ Medication Management for _____
- ☐ Disease Management Instruction for _____
- ☐ Therapeutic Exercises
- ☐ Other: _____

Was the patient in an inpatient facility within the last 14 days?

☐ NO ☐ YES

FAX WITH THIS FORM TO: _____ WITH THE FOLLOWING:

_____ Most Recent Exam Notes _____ Current Medication List _____ Demographic Sheet _____ Insurance Card

PHYSICIAN SIGNATURE: _____ DATE: _____

PROVIDER NAME: _____ PHONE NUMBER: _____