Please fax this form to: (972) 664-0139
Or email: intake@lucenthomehealth.com

info@lucenthomehealth.com

(972) 664-0945

(972) 664-0139

Lucent Home Health

Rapid Referral Form

Patient name: Last, First _____ DOB: _____ HH SOC: _____

I certify that this patient is under my care and that I, or a nurse practitioner or physician's assistant working with me, had a face-to-face encounter that meets the physician face-to-face encounter requirements with this patient on: Date _____

The encounter with the patient was in whole, or in part, for the following medical condition, which is the primary reason for home health care:

Diagnosis	**ICD-10 Code**

I certify that based on my findings and medical necessity, this patient is Home Bound for Home Health Services and is eligible to receive Home Health Services for:

- ☐ Admit to home health
- ☐ SN
- ☐ PT
- ☐ OT
- ☐ ST
- ☐ Home Health Aid
- ☐ MSW

Check any that apply regarding patient's home-bound status (**must select at least 1**):

- ☐ Crutches
- ☐ Canes
- ☐ Wheelchair
- ☐ Walker
- ☐ Special transportation or assistance to leave dwelling
- ☐ Shortness of breath
- ☐ Severe Rest
- ☐ With minimal exertion
- ☐ Supplemental O_2
- ☐ Indoor
- ☐ Supportive device or assistance required
- ☐ Outdoor or even type, PT is medically restricted to home

Check any that apply regarding patient's inability to move (**must select at least 1**)

- ☐ Chair bound
- ☐ Bedbound
- ☐ Medical restrictions
- ☐ Legally blind
- ☐ Residual weakness

Check any that apply regarding patient's limitations on exertion (**must select at least 1**)

- ☐ Increased pain
- ☐ Shortness of breath
- ☐ Muscle weakness
- ☐ Frequent restroom
- ☐ Fall risk
- ☐ Other _____

_____ Physician name

_____ Date of signature