Telfair

HOME HEALTH CARE

www.telfair.care

FAX REFERRAL: 818-937-9165

Sender Name _____

Referral Fax # _____

Phone _____

To: Telfair Intake Team
Tel: (818)937-9160
Fax: (818)937-9165
email: info@telfair.care

Patient Name _____ **DOB** _____

Diagnosis/Skilled Need _____

Insurance _____

ORDERS:

☐ **Home Healthcare** (check all that apply):

☐ Nursing ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy
☐ Social Work ☐ Home Health Aide ☐ Infusion ☐ Dietitian

Please fax the following documents with this referral:

☐ Demographic/Face Sheet ☐ Medication list ☐ History & Physical ☐ MD visit note (most recent)

Comments or Special Instructions

Needs Identified:

☐ Medication Management/Safety (RN) ☐ Strength/Mobility (PT) ☐ Home Safety Assessment (OT)

☐ For Long Term Planning/Placement (SW) ☐ Other _____

Physician Name: _____

Physician Signature _____ Date _____

Direct further orders to (PCP) _____ MD to sign F2F _____