

Telfair

HOME HEALTH CARE

www.telfair.care

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

FAX REFERRAL: 818-937-9165

Sender Name _____

Referral Fax # _____

Phone _____

Patient Name _____ DOB _____

Diagnosis/Skilled Need _____

Insurance _____

ORDERS:

Home Healthcare (check all that apply):

- | | | | |
|--------------------------------------|---|---|---|
| <input type="checkbox"/> Nursing | <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Speech Therapy |
| <input type="checkbox"/> Social Work | <input type="checkbox"/> Home Health Aide | <input type="checkbox"/> Infusion | <input type="checkbox"/> 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 _____

CONFIDENTIALITY NOTICE:

THE DOCUMENTS ACCOMPANYING THIS TRANSMISSION MAY CONTAIN INFORMATION INCLUDING PROTECTED HEALTH INFORMATION THAT IS PRIVILEGED AND CONFIDENTIAL, THE DISCLOSURE OF WHICH IS GOVERNED BY APPLICABLE LAW. YOU, THE RECIPIENT, ARE OBLIGATED TO MAINTAIN IT IN A SAFE, SECURE, AND CONFIDENTIAL MANNER. DISCLOSURE WITHOUT ADDITIONAL PATIENT CONSENT AND AS PERMITTED BY LAW IS PROHIBITED. IF YOU ARE NOT THE INTENDED RECIPIENT, OR THE EMPLOYEE OR AGENT RESPONSIBLE TO DELIVER IT TO THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISCLOSURE, COPYING OR DISTRIBUTION OF THIS INFORMATION IS STRICTLY PROHIBITED. PLEASE NOTIFY THE SENDER BY PHONE IMMEDIATELY IF YOU RECEIVE THIS FAX IN ERROR AND DESTROY ALL COPIES SO RECEIVED.