



Please print clearly. Attach the signed order, recent visit notes or H&P, medication list, and a copy of the insurance card (front and back). Our care coordinator verifies insurance, requests any prior authorization, and calls you within one business day.

Date sent _____

Priority: ☐ Routine ☐ Urgent - needs prompt attention**1. REFERRAL SOURCE**

Your name _____

Organization / practice _____

Phone _____

Fax _____

Email _____

Source: ☐ Physician / NP / PA office ☐ Hospital / discharge planner ☐ SNF / rehab ☐ Case manager ☐ Social worker
☐ Family / caregiver ☐ Patient ☐ Other

2. SERVICES REQUESTEDServices: ☐ Physical therapy - evaluate and treat ☐ Occupational therapy - evaluate and treat

Reason: ☐ Recent hospitalization or surgery ☐ Falls or fall risk ☐ Decline in mobility ☐ Decline in daily activities (ADLs)
☐ Neurological condition ☐ Other

Requested visit frequency, if ordered (e.g. PT 2 visits a week for 4 weeks)
_____**3. PATIENT**

Last name _____

First name _____

Date of birth _____

Phone _____

Sex (as listed on insurance): ☐ Female ☐ Male ☐ X / unspecified

Street address _____

Apt / suite _____

City _____

ZIP _____

County: ☐ King ☐ Snohomish ☐ Pierce ☐ Kitsap ☐ Other: _____

Preferred language _____

Caregiver / emergency contact (name and phone)
_____**4. INSURANCE (ATTACH A COPY OF THE CARD, FRONT AND BACK)**

Primary insurance plan _____

Member ID _____

Group # _____

Subscriber name (if not the patient) _____

Subscriber date of birth _____

Relationship to patient _____

Secondary insurance (if any) _____

Secondary member ID _____

5. ORDERING PROVIDER

Provider name _____

NPI _____

Date provider last saw the patient _____

Practice phone _____

Practice fax _____

Practice address _____

Signed order: ☐ Attached ☐ Please request it from the provider

**6. CLINICAL INFORMATION**

Primary diagnosis ICD-10 code(s)

Hospital / facility discharge date (recent or expected) Hospital / facility name

Homebound? ☐ Yes - leaving home takes considerable effort ☐ No ☐ Not sure

Why is leaving home hard? (e.g. needs walker and help of 1 person; short of breath after 20 feet)

Getting home health from another agency now? ☐ Yes ☐ No ☐ Not sure

Surgery and date (if any) Equipment the patient already has

Weight-bearing: ☐ Full ☐ As tolerated ☐ Partial ☐ Toe-touch ☐ Non-weight-bearing ☐ N/APrecautions: ☐ Fall risk ☐ Hip ☐ Spinal ☐ Sternal ☐ Cardiac ☐ Oxygen

Function before this decline, and now (e.g. walked in the community without a device; now needs a walker and help to bathe)

Clinical notes - anything our clinician should know before the first visit

7. WHEN IS CARE NEEDED?

Earliest start date Preferred visit days / times

8. DOCUMENTS ATTACHED☐ Signed order ☐ Recent visit notes or H&P ☐ Discharge summary ☐ Medication list ☐ Insurance card

Referring person signature Date