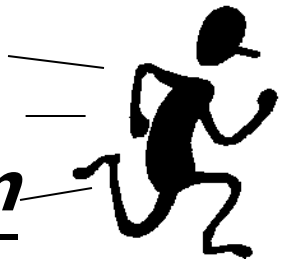
healthy connections
HOME CARE SERVICES
an Option Care company

Quick Referral Form



Date:_____

PLEASE ATTACH THE FOLLOWING DOCUMENTS WHEN YOU FAX YOUR REFERRAL:

☐ PHYSICIAN ORDERS, ☐ PRENATAL RECORDS, ☐ LAB REPORTS,
☐ INSURANCE INFORMATION, AND ☐ DEMOGRAPHICS

Full Name	DOB	SSN	EDC

Address	Apt. No.	City	State	Zip Code

Primary Phone Number	Secondary Phone Number	Marital Status

Primary Insurance Provider	ID Number	Policy Holder / Relationship to Patient	DOB

REQUEST FOR SERVICES:

OFFICE USE: Pt. ID #:

Physician Name _____ Office Contact Staff Member _____

Office Contact Phone Number _____ Ext. _____ Office Fax Number _____

Which Physician Will be MANAGING Patient's Home Care? _____

Hospital Name _____ Hospital Phone Number _____ Hospital Room Number _____

PLEASE CHECK ALL SERVICES NEEDED:

NAUSEA/VOMITING PROGRAMS:
- ☐ Ondansetron Pump + IV Hydration
- ☐ Metoclopramide Pump + IV Hydration
- ☐ PICC Line Maintenance
- ☐ Total Parenteral Nutrition (TPN)
- ☐ Hydration w/ PICC Line Maintenance

PRE-TERM LABOR PROGRAM:
- ☐ Skilled Nursing Visit/ Makena® Administration
- ☐ Medication Only

GESTATIONAL DIABETES PROGRAMS:
- ☐ Gestational Diabetes Program
- ☐ Insulin Instruction

OTHER PROGRAMS:
- ☐ Hypertension in Pregnancy
- ☐ OTHER: _____

ADDITIONAL COMMENTS:

WE APPRECIATE YOUR BUSINESS!

FAX: 1.877.865.9133

EMAIL TO:
EFAX-HEALTHYCONNECTIONSINTAKE@OPTIONCARE.COM

PHONE: 1.888.304.1800

MEMBER Texas Association for Home Care & Hospice Care Stronger

The Joint Commission – National Quality Approval

Revised 05/23/2017