SOUTHEASTERN
Home Health
an AccentCare® Company

# Home Health Care Referral/Order

*Please complete this form in its entirety and fax to the Intake Fax number listed at the bottom.*

## PATIENT CONTACT INFORMATION

**Last Name:** **First Name:** **Middle Initial:** **Sex:**

**Date of Birth:** **Medicare ID #:**

**Street Address:** **Apt #:**

**City:** **State:** **Zip Code:**

**Home Phone:** **Cell Phone:**

**Emergency Contact:** **Phone:**

**Power of Attorney:** **Phone:**

## PATIENT INSURANCE INFORMATION

**Primary Insurance:**

**Name of Insurance:** **Policy #:** **Group #:**

**Patient's Relationship to Policy Holder:**

**Secondary Insurance:**

**Name of Insurance:** **Policy #:** **Group #:**

**Patient's Relationship to Policy Holder:**

## REFERRAL INFORMATION

**Primary Diagnosis (including medical conditions):**

**Secondary Diagnosis (please list all that apply):**

**Evaluate and Treat (check all that apply:**

☐ SN ☐ PT ☐ OT ☐ ST ☐ HHA ☐ MSW

**Additional Orders:**

**Recent Hospitalization:** **Date(s):**

☐ Yes ☐ No

**Southeastern Program(s) to include in patient's treatment plan:**

☐ COPD ☐ Cardiac Care ☐ Diabetes Care ☐ Joint Rehabilitation ☐ Late Life Depression/Dementia Care/Behavioral Health ☐ Supportive Care

**Additional information included with this faxed form (please send all available):**

☐ History/Physical ☐ Progress Notes (3 months) ☐ Medication List ☐ Lab Report(s) ☐ Face-to-Face COVID-19 Vaccine (Circle) No 1 Shot 2 Shots Booster

**Signing or Following Physician/Provider Signature:** **Date Signed:** **Phone:**

**Referral Source:** **Phone:**

**Primary Care Physician:** **Phone:**

**Account Executive Name:** **Phone:**

**Phone: 1-866-285-2007** **Intake Fax: 1-855-620-7447**