ATLANTA HOUSE
Healthcare Services

Email completed form to Referrals@AtlantaHouseCares.com

Or Fax us at 404-407-5773 Customer Care Phone: 404-492-8539

Home Health Referral Form

Referral source: _____ Contact: _____ Phone: _____

_____

*Required field **PATIENT INFORMATION**

*Patient full name: _____ *Phone: _____

*Address: _____

*DOB: _____ SSN: _____

*Insurance Provider: _____ MRN#: _____ Phone: _____

*Address (of care provision): _____

*Emergency contact: _____ *Phone: _____

Discipline: _____

ORDERS	Focus of care
◯ Skilled nursing	
◯ Personal Care Asst	
◯ Companionship	
◯ Sitter Services	
◯ Other	

Additional orders or information about the patient you would like us to know so we can provide excellent care:

*Healthcare practitioner signature and credentials: _____

*Healthcare practitioner printed name: _____ *Date: _____

Requested information - *Please send these documents to support a safe patient hand-off*

- Recent clinical notes, H&P, labs
- F2F encounter visit note
- Most recent HbA1C (diabetic patients)
- Current medication list
- Most recent assessment of primary reason for home health

Primary reason(s) for referral: _____

Healthcare practitioner who will oversee healthcare: _____

Please provide any additional information that may be helpful: