Home Health Referral Form

Intermountain Health

PATIENT INFORMATION		INSURANCE INFORMATION	
NAME:		PRIMARY INSURANCE:	
DATE OF BIRTH:		POLICY #:	
ADDRESS:		SECONDARY INSURANCE:	
CITY/STATE/ZIP:		POLICY #:	
PHONE:		PHYSICIAN:	
PRIMARY DIAGNOSIS:			

MY CLINICAL FINDINGS SUPPORT THE NEED FOR THESE HOME HEALTH SERVICES

☐NURSING CARE	FOR	☐MEDICATION MANAGEMENT	☐WOUND CARE
☐HOME HEALTH AIDE		☐SURGICAL RECOVERY	☐IV THERAPY
☐PHYSICAL THERAPY		☐PAIN MANAGEMENT	☐ADLs
☐SPEECH THERAPY		☐EVALUATION/TREATEMENT	☐CHRONIC ILLNESS SUPPORT
☐OCCUPATIONAL THERAPY		OTHER:	
START OF CARE DATE:			

THIS REFERRAL INCLUDES THE FOLLOWING PAPERWORK

	ALL INFORMATION IS IN EPIC		
	AND/OR		
	PATIENT DEMOGRAPHICS		DETAILED WOUND CARE ORDERS
	UPDATED MEDICATION LIST		DISCHARGE SUMMARY
	RECENT HISTORY AND PHYSICAL		OFFICE NOTES
	SIGNED MD ORDERS		OTHER:

WHO SHOULD WE CONTACT AT YOUR OFFICE?	
WHAT TIME IS BEST FOR US TO CALL YOU TODAY?	

PLEASE FAX THIS FORM & DOCUMENTATION TO

801-442-0709

THANK YOU FOR CHOOSING HOME HEALTH SERVICESAT INTERMOUNTAIN HEALTH.

Revised 8-20-2025