

DOCTOR REFERRAL FORM

Date: 2025-11-03

PATIENT INFORMATION

First Name:	John
Last Name:	Doe
Date of Birth:	1958-09-03
Gender:	Male
Address:	1234 Elm Street, Apt 56, Springfield, IL 62704, USA
Phone:	+1-217-555-0123
Primary Language:	English
Insurance / Payer:	Blue Cross Blue Shield - PPO
Policy Number:	BCBS-987654321

DIAGNOSIS / REASON FOR HOME HEALTH

Post-operative care after right knee replacement.
Requires physical therapy, wound monitoring, and medication management.
Home environment suitable for outpatient care.

SERVICES REQUESTED

- Nursing care
- Physical therapy
- Medication management

REFERRING PHYSICIAN

Name:	Dr. Michael Andrews
Specialty:	Orthopedic Surgery
Clinic:	Springfield Orthopedics Clinic
Address:	200 Medical Plaza, Springfield, IL 62704, USA
Phone:	+1-217-555-0199
Email:	m.andrews@springfieldortho.com

ADDITIONAL NOTES

Please initiate home health admission within 48 hours. Patient's daughter, Jane Doe, will be the primary contact for coordination.

DOCTOR SIGNATURE: _____

NOTICE: This document contains protected health information (PHI). Handle in accordance with HIPAA rules. For testing purposes only
Signature Date: 2025-11-03