Referral Form

HORIZON

Call Admissions : (323) 676-1000 x1
Fax Admissions: (323) 676-2000
Urgent Clinical Inquiries: (323) 676-1000 x5
www.horizoncenters.org

Please complete form & Fax or Email with supporting documentation to admissions@horizoncenters.org

Referral Source (circle one): Hospital - ED - Health Plan - IPA		Attending MD:
SW/CM:	Phone#	Email:
Clinical Nurse:	Phone#	Email:

Patient's Full Name:			DOB: / /
Insurance:	ID#		Gender:
DX:		HX:	
Date Admitted: / /	Height:	Weight:	Allergies:
Projected DC: / /	Surgery:		Surgeon:
Responsible Payor:	Days Approved:		

ADLs

- Can Patient Self Represent? ☐ YES ☐ NO
- Is Patient Independant w/ ADLs? ☐ YES ☐ NO
- Insulin Dependant? ☐ YES ☐ NO
- Continent with bowel? ☐ YES ☐ NO
- Continent with bladder? ☐ YES ☐ NO
- Colostomy care? ☐ YES ☐ NO
- Catheter care? ☐ YES ☐ NO
- Isolation ☐ YES ☐ NO

If Yes, explain: _____

DME DEPENDANT

(Referring entity to arrange all DMEs prior to admission)

- Walker ☐ YES ☐ NO
- Cane ☐ YES ☐ NO
- Crutches ☐ YES ☐ NO
- Wheel Chair ☐ YES ☐ NO
- Oxygen ☐ YES ☐ NO
- Wound Vac ☐ YES ☐ NO

HOME HEALTH

- IV Antibiotics ☐ YES ☐ NO
- Physical Therapy ☐ YES ☐ NO
- Medication Management & Education ☐ YES ☐ NO
- Name of Home Health: _____

WOUND CARE

- Wounds? (Attach wound report and orders) ☐ YES ☐ NO
- Can PT perform wound care? ☐ YES ☐ NO
- Home Health Care will be coordinated ☐ YES ☐ NO
- Recup will provide wound care? ☐ YES ☐ NO

MENTAL HEALTH

- Bipolar ☐ YES ☐ NO
- Depression ☐ YES ☐ NO
- Schizophrenia ☐ YES ☐ NO
- History of Violence ☐ YES ☐ NO
- Sex Offender ☐ YES ☐ NO

SUBSTANCE ABUSE

- Alcohol ☐ YES ☐ NO
- Cocaine ☐ YES ☐ NO
- Heroin ☐ YES ☐ NO
- Methamphetamines ☐ YES ☐ NO
- Methadone Clinic Needed? ☐ YES ☐ NO

Follow Up Appointments Needed: _____

Please attach Documents:

☐ Face Sheet ☐ CXR or PPD (within last year) ☐ Covid Test (within 1 week) ☐ H&P ☐ Med List

☐ S.W. Notes ☐ Recent PT/OT notes ☐ Surgical Notes (if any) ☐ Wound Care Notes (if any)