

**American Home Health Care LLC  
Recuperative Care  
Referral Form**

**Phone:**763-334-6957 **Fax:** 763-334-6958| ✉ info@ahealthcarehome.com  
www.ahealthcarehome.com

**Referrer Contact Information**

Name: \_\_\_\_\_

Agency / Role: \_\_\_\_\_

Email Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Client Information**

Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email Address (if applicable): \_\_\_\_\_

PMI# (if available): \_\_\_\_\_

**Medical Information**

Primary Diagnosis / ICD-10 Code(s): \_\_\_\_\_

Primary Care Clinic / Health Provider: \_\_\_\_\_

Current Medical Needs:

Medication Management

Wound Care

Mobility Assistance

Nutrition / Meal Support

Other: \_\_\_\_\_

Hospital Discharge Date (if applicable): \_\_\_\_\_

Discharging Facility: \_\_\_\_\_

**Signature**

### Reason for Referral

- Client is medically stable but lacks housing during recovery
- Recently discharged from hospital with continued care needs
- Needs 24/7 supervision or transitional support
- No safe or stable housing environment
- Other (describe): \_\_\_\_\_

### Supporting Documents (Required to Process Referral)

- Discharge Summary
- Care Plan / Treatment Orders
- COVID-19 Test Results or Vaccination Status
- Insurance Information (if applicable)

### Client Authorization for Referral

I, \_\_\_\_\_, authorize my referral to American Home Recuperative Care for short-term recuperative services.

Client or Case Manager Signature: \_\_\_\_\_

Date: \_\_\_\_\_