LTC Health Solutions

Fax Referral Form

Care Management Program

Phone: (800) 491-0909
Fax: (844) 381-6782
Email: Call_Center@LTCHS.com

Patient Information (Please Print)**:** **Date:**_____

First Name:	M.I.	Last Name:
Family Contact:		Contact Number:
Home Health Agency:		Contact Number:
PCP:		

Referrer Information (Please Print)**:**

Facility Name:
Contact Person:
Contact Number:

Please attach the following items:

- ☐ FACE SHEET
- ☐ H & P
- ☐ DISCHARGE SUMMARY
- ☐ CURRENT MEDICATION LIST

*Our Care Management Coordinators will call your referral. Please check the **BEST** time frame for them to be reached:*

- ☐ 9 A.M. - 12 P.M.
- ☐ 12 P.M. - 3 P.M.
- ☐ 3 P.M. - 6 P.M.
- ☐ 6 P.M. - 9 P.M.