FAST TRACK HOSPICE REFERRAL

FAX BACK TO (855) 782-6508 WITH YOUR COVER SHEET

If you have a patient who might benefit from hospice services, please complete and return this form.
A hospice specialist will follow up promptly.

REQUIRED INFORMATION

PATIENT NAME: _____ GENDER: ☐ M ☐ F DATE OF BIRTH: _____

PATIENT'S ADDRESS: _____ PATIENT'S PHONE NUMBER: _____

HOSPICE DIAGNOSIS: _____

ATTENDING PHYSICIAN: _____

REFERRAL CONTACT NAME: _____ REFERRAL CONTACT PHONE NUMBER: _____

HAS HOSPICE BEEN DISCUSSED WITH THE PATIENT/FAMILY? __ YES __ NO

SUPPORTING INFORMATION

☐ DOCUMENTS ATTACHED TO FAX ☐ PLEASE SEND A REPRESENTATIVE TO COLLECT DOCUMENTS

If you have the following supporting documentation, please provide as appropriate:

- PATIENT FACE SHEET (DEMOGRAPHICS)
- PATHOLOGY REPORTS
- HISTORY AND PHYSICAL
- DISCHARGE SUMMARY
- LAST VISIT NOTE
- LABS
- MEDICARE/MEDICAID/COMMERCIAL INSURANCE CARD
- ADDITIONAL INFORMATION

COMMENTS: _____

_____

_____

_____

ORDERS

☐ EVALUATE AND ADMIT TO HOSPICE SERVICES.

Please choose one box below:

☐ Hospice medical director to assume care of the patient.

☐ Dr _____ will remain attending physician.

☐ Dr _____ will remain attending physician with hospice medical director to assist with signs and symptoms management.

Additional orders: _____

For physicians: please sign here to authorize Cnfejtzt to evaluate and admit patient, if eligible.

Physician Signature: _____ Date: _____

Physician Name (print): _____

WE LOOK FORWARD TO SERVING YOU AND YOUR PATIENTS.

amedisys
HOSPICE

MI-003-HSP REV 05/2017