

HOSPICE RAPID REFERRAL FORM



**Assured
Hospice**

P: 503.570.9766 • F: 503.685.5022

PATIENT INFORMATION

Name _____ DOB _____

Phone _____

Medicare/Medicaid or Insurance # _____

Diagnosis _____

____ I authorize the use of telehealth and telecommunications as necessary and appropriate for this patient's treatment

☐ Hospice Evaluation and admit to hospice if Appropriate

☐ If admitted, and patient chooses, I wish to remain the patient's primary attending physician

☐ If admitted, and patient chooses, have _____
or the local medical director serve as attending

PHYSICIAN SIGNATURE: _____ DATE: _____

PLEASE PRINT NAME: _____

☐ Face Sheet, MAR, H&P attached.

Last updated 4.9.20