HOSPICE
RAPID REFERRAL FORM

Community Loving Care Hospice
P: 573.324.9828 • F: 573.324.3026

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