

HOSPICE RAPID REFERRAL FORM



HEART of HOSPICE

P: 225.412.2614 • F: 225.412.3660

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