

# HOSPICE RAPID REFERRAL FORM

HOSPICE OF  
**WILSON**  
P: 252.640.2400 • F: 252.364.4032

## 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