QUALITY HOSPICE FAX REFFERAL FORM **PLEASE FAX TO (931)879-9338 OR**

(931) 879-9330 **EMAIL JJONES@QUALITYHOMEHEALTH.COM**

TODAY'S DATE____/____/____ PRIMARY PHYSICIAN:_______________________PHONE #_____________

REFERRAL INFORMATION

PATIENT NAME____

DOB____/___/____ SOCIAL SECURITY #_____________________________________

PHONE #___________________________

ADDRESS:____

MEDICARE #____

PRIVATE INSURANCE____

TERMINAL DIAGNOSIS:____

IS PATIENT COMPETENT TO SIGN CONSENT FOR HOSPICE CARE: YES NO IF NOT, PLEASE PROVIDE POA INFORMATION:____

NEXT OF KIN NAME:____ RELATIONSHIP________________

PLEASE FAX OR EMAIL THE FOLLOWING INFORMATION WITH THIS REFERAL FORM:

- DEMOGRAPHIC PAGE
- CURRENT MEDICATION LIST
- MOST RECENT H&P
- HOSPITAL DISCHARGE SUMMARY OR RECENT OFFICE VISIT NOTES
- COPY OF PHYSICIAN ORDER FOR HOSPICE CARE