

# HOSPICE RAPID REFERRAL FORM



REYNOLDS HOSPICE HOUSE

P: 901.861.5700 • F: 901.861.5673

## 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