

HOSPICE RAPID REFERRAL FORM



HEART of HOSPICE

P: 918.647.7008 • F: 918.647.7168

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