Unity Hospice Care

Hospice Referral

Please complete and FAX this form to 901-756-7085. A hospice intake coordinator will follow up.

Patient Information

Patient Name: _____

DOB: _____ SSN: _____ Race: _____ Sex: _____

Type of Residence: ☐ Home ☐ Nursing Home ☐ Assisted Living ☐ Group Home ☐ Other: _____

Address: _____ City: _____ State: _____ Zip: _____

Patient's Phone Number: _____ Caregiver's Phone Number: _____

Referral Contact Name: _____ Contact Phone Number: _____

Attending Physician: _____ Contact Phone Number: _____

Primary Hospice Diagnosis: _____

Secondary Diagnosis: _____

Has patient and/or family informed about hospice admission? ☐ Yes ☐ No

☐ The following documents are attached (fax) to this referral ☐ Prefer Hospice Representative pick up documents

- ☐ Patient Face Sheet
- ☐ History & Physical
- ☐ Discharge Summary
- ☐ Medicare/Medicaid/Commercial Insurance Card
- ☐ Labs
- ☐ Pathology Reports

Payment Source

MCA: _____ MCD: _____

Insurance Company: _____ Phone: _____

Policy Number: _____ Group Number: _____

Orders

☐ Evaluate and Admit into Hospice.

Please choose one box below:

☐ Hospice Medical Director to assume care of the patient.

☐ Dr. _____ will remain attending physician.

☐ Dr. _____ will remain attending physician with Hospice Medical Director to assist with signs and symptoms management.

Physicians: Please sign to authorize Unity Hospice Care to evaluate and admit the patient, if eligible for hospice.

Physician Signature: _____ Date: _____

Physician Name (Print): _____

Thank you for the opportunity to care for your patients.