



ADORATION
HOSPICE

FAX: 615.733.9988
PHONE: 615.733.3600

REFERRAL ORDER FOR HOSPICE

REFERRAL INFORMATION

CALLER: _____ CALLER PHONE NUMBER: _____ REFERRAL TAKEN BY: _____

TODAY'S DATE: ____ / ____ / ____ REQUESTED SOC DATE: ____ / ____ / ____ *If no SOC date noted, care provided within 48 hours.*

PHYSICIAN'S NAME: _____ TELEPHONE: _____

NPI #: _____ OFFICE CONTACT: _____

FACILITY NAME: _____ FACILITY CONTACT: _____

How did you hear about Adoration Hospice?

PATIENT INFORMATION

PATIENT NAME: _____ DOB: ____ / ____ / ____

STREET ADDRESS: _____ APT #: _____ SSN: _____

CITY: _____ STATE: _____ ZIP: _____ PHONE: _____

ALLERGIES: _____

CAREGIVER/EMERGENCY CONTACT INFORMATION

NAME: _____

RELATIONSHIP: _____

PHONE: _____

HOME WORK CELL

INSURANCE INFORMATION

PATIENT MEDICARE #: _____

INSURANCE CARRIER: _____

INSURANCE ID: _____

POLICY HOLDER NAME: _____

POLICY HOLDER DOB: _____

PRIMARY DIAGNOSIS: ICD-9: _____ PLEASE DESCRIBE: _____

OTHER RELEVANT DIAGNOSES: _____

MEDICAL DOCUMENTATION REQUEST

TO BEST SERVE YOUR PATIENT, PLEASE INCLUDE ALL RELEVANT MEDICAL DOCUMENTATION AND FORMS, INCLUDING, WHERE APPLICABLE, THOSE PERTAINING TO HISTORY & PHYSICAL, DISCHARGE SUMMARY, PATIENT DEMOGRAPHICS, LAB/X-RAY, and HOSPICE ORDER.

IF DISCLOSING OTHER DOCUMENTATION, PLEASE DESCRIBE:

PHYSICIAN AUTHORIZATION

I CERTIFY THAT THIS PATIENT IS UNDER MY CARE AND THAT HE OR SHE IS TO BE PROVIDED HOSPICE SERVICES.

PHYSICIAN'S SIGNATURE: _____ **DATE:** ____ / ____ / ____