ADORATION® HOSPICE

**FAX: 800.648.0896**
**PHONE: 800.643.6656**

**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**: _____ / _____ / _____