ADORATION® HOSPICE

FAX: 800.595.3773
PHONE: 800.202.9444

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**: _____ / _____ / _____