6929 Sunrise Blvd. Suite 180, Citrus Heights Ca. 95610
Phone 916-725-2580 Fax 916-725-2511

HOSPICE REFERRAL/REQUEST FOR SERVICES

Fax to	**FIRST CALL HOSPICE 916-725-2511 (this is a secure fax)**
From	**Dr. _____**
Regarding	Patient Name DOB Primary Diagnosis
Physician Orders	Please evaluate this patient for Hospice services and if the patient meets the criteria please admit to hospice. Other:
Please Find Attached	☐ Face Sheet with: Phone Number, Address, Insurance, ***If not included in the face sheet, please provide*** Patient phone number(s)_____ Patient Address:_____ Insurance: ☐ Medicare ☐ Medical ☐ Private_____ # _____ # _____ ☐ History and Physical and or Office Notes (if available) ☐ List of Medications (if available) ☐ Labs ☐ X-Rays ☐ Discharge Summaries ☐ Other

Physician Signature Date