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 Phone 916-725-2580 Fax 916-725-2511

HOSPICE REFERRAL/REQUEST FOR SERVICES

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| 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 | <input type="checkbox"/> Face Sheet with: Phone Number, Address, Insurance, <i>If not included in the face sheet, please provide</i> Patient phone number(s) _____ Patient Address: _____ Insurance: <input type="checkbox"/> Medicare <input type="checkbox"/> Medical <input type="checkbox"/> Private _____ # _____ # _____ <input type="checkbox"/> History and Physical and or Office Notes (if available) <input type="checkbox"/> List of Medications (if available) <input type="checkbox"/> Labs <input type="checkbox"/> X-Rays <input type="checkbox"/> Discharge Summaries <input type="checkbox"/> Other _____ _____ _____ |
| Physician Signature | Date |

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