FAST TRACK HOSPICE REFERRAL

FAX BACK TO AMEDISYS AT (855) 782-6508. PLEASE INCLUDE YOUR COVER SHEET.

If you have a patient who might benefit from hospice services, please complete and return this form.

REQUIRED INFORMATION

PATIENT NAME: _____ GENDER: ☐ M ☐ F DATE OF BIRTH: _____

PATIENT'S ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

Does the patient reside in a facility? ☐ YES ☐ NO IF YES, FACILITY NAME: _____

HOSPICE DIAGNOSIS: _____ PATIENT'S PHONE NUMBER: _____

ATTENDING PHYSICIAN: _____

PATIENT'S PRIMARY CONTACT NAME: _____ PATIENT'S PRIMARY CONTACT NUMBER: _____

Who should we contact to discuss our services? ☐ PATIENT ☐ PATIENT'S PRIMARY CONTACT

Has hospice been discussed with the patient/family? ☐ YES ☐ NO

REFERRAL CONTACT NAME: _____ REFERRAL CONTACT PHONE NUMBER: _____

SUPPORTING INFORMATION

☐ DOCUMENTS ATTACHED TO FAX ☐ PLEASE SEND A REPRESENTATIVE TO COLLECT DOCUMENTS

If you have the following supporting documentation, please provide as appropriate:

- Patient Face Sheet (Demographics)
- Pathology Reports
- History and Physical
- Discharge Summary
- Last Visit Note
- Labs
- Medicare/Medicaid/Commercial Insurance Card
- Additional Information

COMMENTS: _____

ORDERS

☐ EVALUATE AND ADMIT TO HOSPICE SERVICES.

Please choose one box below:

☐ Hospice medical director to assume care of the patient.

☐ Dr. _____ will remain attending physician.

☐ Dr. _____ will remain attending physician with hospice medical director to assist with signs & symptoms management.

DME ORDER:

☐ APP
☐ Bedside Commode
☐ Hospital Bed
☐ Oxygen
☐ Wheelchair
☐ Other: _____

ADDITIONAL ORDERS: _____

For physicians: please sign here to authorize us to evaluate and admit patient, if eligible.

PHYSICIAN SIGNATURE: _____ Date: _____

PHYSICIAN NAME (PRINT): _____

A hospice specialist will follow up promptly. **We look forward to serving you and your patients.**

amedisys
HOSPICE

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