



Reaching Higher To Serve You

## Hospice Referral Fax Form

Please Fax to: 1-866-682-6164

Office Phone: 404-763-1456

Fax Referral line is monitored 24 hours a day, seven days a week.

Fax Referrals will be acknowledged. If you do not receive a confirmation call within 30 minutes, please contact our referral office at 404-763-1456. Please provide a phone number to confirm receipt of referral \_\_\_\_\_.

Patients Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Please evaluate and admit patient to Agape Hospice Care if appropriate.

\_\_\_\_ Please turn over care to the hospice Medical Director.

\_\_\_\_ I will remain the attending physician for this patient.

\_\_\_\_ I wish to remain attending, but turn over hospice care to hospice medical director

Physician Signature \_\_\_\_\_ Date: \_\_\_\_\_

Physician Name (Printed) \_\_\_\_\_

**Please include the following: Face Sheet, H&P, Labs, Recent Notes and any documentation to support the patients terminal diagnosis.**

Please Provide Any Additional Comments: \_\_\_\_\_

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