PATIENT REFERRAL & ORDER FORM

Altruist may request medical records from Physicians. Please retain supporting documentation such as d/c summary, labs, last office visit note and medication profile in your medical record.

Please complete and fax the following information (or attach demographics / face sheet) and/or office visit notes to: **(972) 692-8888**

PATIENT

Patient Name: _____ SSN: _____

Date of Birth: _____ M F Address: _____

Phone: _____ City, State, Zip: _____

Alternate Contact Name: _____

Alternate Contact's Number: _____ Contact's Relationship: _____

Medicare or Medicaid: _____
(or Private Pay)

REFERRER

Referring Source: _____ Contact Name: _____

Office Contact eMail: _____ Contact Phone: _____

Referral Date: _____ Discharge Date: _____

Referring Physician: _____

Address: _____ City, State, Zip: _____

Physician Phone: _____ Physician Fax: _____ Physician eMail: _____

Admit to Hospice: PRIMARY ☐ OTHER ☐

PRIMARY DIAGNOSIS / MEDICAL CONDITION: (List the medical conditions that are the primary reason the patient requires hospice care.)

CERTIFICATION FOR FACE-TO-FACE ENCOUNTER

I wish to remain with the attending physician, but would prefer for Altruist Hospice to care for all symptoms regarding hospice diagnosis and comfort care. [Please Initial] _____

I prefer that Altruist Hospice have full-control over the patient. [Please Initial] _____

I certify that this patient is under my care and that this patient has six months or less to live if the disease process stays its natural course and would benefit from hospice services (Insert date the face-to-face visit occurred) _____/_____/_____

Physician's Printed Name: _____

Physician Signature: _____ Date: _____