HOSPICE *Referral Form*

Phone: **(757) 496-1653** | *Fax*: **(757) 496-1771**

Today's date: _____ /_____ /_____

REQUEST FOR CONSULTATION: ❑ PHYSICIAN ❑ FAMILY

PATIENT INFORMATION

Patient ID (office use only)	Request Admission Date _____ /_____/_____	Office Name / Contact Person /

Last Name	First Name	Middle Name

DOB _____/_____/_____	SSN	Gender ❑ M ❑ F	M/S

Street Address	City	State	Zip

Phone	Alternate Phone	Email

Insurance: ❑ Medicare ❑ Other: _____	Medicare # / Policy #

DME Equipment Needed ❑ Yes or ❑ No	List of Equipment Needed:

POA or POINT OF CONTACT INFORMATION

Last Name	First Name	Relationship	Sex ❑ M ❑ F

Street Address	City	State	Zip

(H) Phone	(M) Phone	Email

ORDERING PHYSICIAN INFORMATION

Physician Name #1	Phone	Fax

Street Address	City	State	Zip

Doctor Aware?

Reason for HOSPICE (in words of referral source)	Where is the patient now?	
	Who should be called to set up initial appointment?	
	Appointment TIME / DATE	
	Physician Signature:	Date:

A Medicare Certified and CHAP Accredited Hospice Agency

WCAH *Revised: Oct 2022*

Office use: Entered into the computer by: