



Ph. (704) 637-7645
Fax (704) 637-9901
Fax (336) 714-6900

Serving 5 counties
•Cabarrus •Davidson •Iredell •**Rowan** •Stanly

To: _____
Fax #: (336)714-6900
Ph #: _____

From: _____
Fax #: _____
Ph #: _____
Date: _____

Please provide the information requested below via fax.

Physician request for patient assessment and admission to hospice services.

Attending physician certifies that to the best of their medical knowledge, this patient is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course.

Patient Name: _____ DOB: _____

Diagnosis/ICD-10 Code: _____

(Name of Attending Physician/NP) certifies the patient is terminally ill and agrees to follow as the patient's attending physician for hospice services.

Referring physician will not follow as hospice attending.

Requested Documentation

To expedite the referral process, please provide the following documents if available.

<input type="checkbox"/> Demographic Information	<input type="checkbox"/> Consultation Reports
<input type="checkbox"/> Current Medication List	<input type="checkbox"/> Laboratory Reports
<input type="checkbox"/> Physician notes	<input type="checkbox"/> Diagnostic Reports
<input type="checkbox"/> History & Physical	<input type="checkbox"/> H&P or D/C Summary from last hospitalization

Confidentiality Notice: The information contained in this facsimile message may be privileged and is confidential information intended for the use of the addressee listed above. If you are neither the intended recipient nor the employee or agent responsible for delivering this message to the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this information is strictly prohibited. If you have received this telecopy in error, please immediately notify us by telephone (you may call "collect") to arrange for return of the original documents to us.