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Serving 5 counties

•Cabarrus •Davidson •Iredell •**Rowan** •Stanly

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

From: _____
Fax #: _____
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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 |

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