TRELLIS Supportive Care
ROWAN

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

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

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

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

☐ Referring physician will not follow as hospice attending.

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

- ☐ Demographic Information
- ☐ Current Medication List
- ☐ Physician notes
- ☐ History & Physical
- ☐ Consultation Reports
- ☐ Laboratory Reports
- ☐ Diagnostic Reports
- ☐ H&P or D/C Summary from last hospitalization