AuthoraCare HOSPICE

Referral Fax 336.478.2541

To confirm receipt of fax, call the Referral Center: 336.621.7575

Patient Name:_____

Date of Birth:_____/_____/_____ **SSN:**_____

Physician Order for: *(check appropriate boxes)*

❒ AuthoraCare staff to assess prognosis and eligibility for admission. Admit if eligible.
❒ This patient is considered terminally ill and has a life expectancy of six months or less, if the terminal illness runs its normal course.

Reason(s) for Referral: *(check appropriate boxes)*

❒ Symptom management ❒ Frequent ED/Hospital visits ❒ Caregiver concern ❒ Functional decline ❒ Weight loss

Additional comments:_____

Physician Order Requests:

Attending: *(check one)*

❒ I will serve as this patient's attending physician.

❒ I am making the hospice referral and will defer the attending of record to be another member of the patient's health care team.

The patient will likely select the following health care provider as their attending of record:

Physician Name_____ Practice_____
Contact Number_____

Previous Hospice Patient?	Home Health Vendors Currently Involved?
❒Yes _____	❒Yes _____
❒No	❒No

Fax these medical records (if applicable) with this sheet for proof of diagnosis/ continuity of care to 336.478.2541

Terminal Illness:_____

1. Demographic/patient information form:
   - Contacts.
   - Reimbursement information.
2. Medical problem list.
3. Medication list.
4. Current wt. Wts. last six to 12 months.
5. Recent labs including CBC, CMET (for albumin).
6. CXR, CT scan, MRIs, bone scan, PET scan, ultrasound reports.
7. Two-D Echo, cardiac cath records including EF (most recent).
8. Recent office visit notes.
9. Treatment plan/chemo and/or radiation therapy plans.
10. List of ongoing cafe/procedures at day hospital.
11. PFTs/ABG records, oxygen requirements, pulse oxygenation.
12. Tube feeding, TPN, IV fluid needs.
13. Skin care needs, VAC system.
14. Code status and goals of care (possibly verbal).

_____ _____ ___/___/___ ___:___ a.m. p.m.

Referring Physician Name **Physician Signature** (required) **Date**

AuthoraCare Referral Center: Monday-Friday 8:30 a.m. - 5 p.m. 336.621.7575
For emergency needs after business hours and on weekends, call 336.621.8800.