Serving Rockingham County and surrounding area

To refer by phone, call 336-427-9028
To fax a referral during business hours: 336-427-9030
To fax a referral after hours/weekends: 336-427-0744

Date: ______________________________

Office: ______________________________

Phone: ______________________________

Physician: ______________________________

Office contact person: ______________________

HOSPICE REFERRAL

Please fill out the information indicated below. We only need a name and a method of contact, but additional information helps us to determine how best to support your patient.

We are available 24 hours a day, 7 days a week, 365 days a year.

Patient name: ____

Address: ____

Phone: ____

Select the patient's illness(es):

___ Alzheimer's/Dementia
____ Cancer
____ Neurological Disorders
___ Cardiac Disease
____ HIV
____ Non-disease Specific
___ Pulmonary Disease
____ End-stage Renal Disease
____ Liver Disease

Tell us more about what is happening with the patient:

Attaching copies of the following will help expedite the referral:

- ❒ Insurance information or copy of insurance cards/**SSN**
- ❒ History and Physical, office notes that support hospice care need
- ❒ Medication List

Order to evaluate for hospice services and admit if eligible:

____ **Date**: _____/_____/_____

Provider signature

Printed Provider Name ____

_____ **I will serve as attending**

_____ **I will not serve as attending**