



# Physician Referral to Hospice

**Phone: 888-771-9099**  
**Fax: 801-771-0200**

**Time:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*Please call to verify that we have received your fax.  
After 5:00 p.m. and on weekends please call before faxing form.*

**Patient Name:** (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_  
**Date of Birth:** \_\_\_\_\_ **Gender:** \_\_\_\_\_  
**Soc. Sec. #:** \_\_\_\_\_ **Married:** \_\_\_\_\_

**Location:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**Contact Person:** \_\_\_\_\_ **Tel.:** \_\_\_\_\_  
**Contact Person:** \_\_\_\_\_ **Tel.:** \_\_\_\_\_  
**Contact Person:** \_\_\_\_\_ **Tel.:** \_\_\_\_\_  
**When/How to Contact:** \_\_\_\_\_

**Medicare:** Yes/No **Medicare #:** \_\_\_\_\_  
**Medicaid:** Yes/No **Medicaid #:** \_\_\_\_\_  
**Private Insurance:** Yes/No Carrier: \_\_\_\_\_  
Group #: \_\_\_\_\_  
Tel.: \_\_\_\_\_ Case Manager: \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_  
**Other Symptoms:** \_\_\_\_\_  
\_\_\_\_\_

**Attending Physician:** \_\_\_\_\_  
**Tel.:** \_\_\_\_\_ **Fax:** \_\_\_\_\_  
**Physician's Contact:** \_\_\_\_\_ **upin#:** \_\_\_\_\_

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- -Assessment/Consultation/Explanation for patient/family to see if appropriate for Hospice. Then Communicate back to Attending Physician before admitting to Hospice Care.
  - -Assessment/Consultation/Explanation for patient/family and then if appropriate, admit to Hospice Care services.
  - -Admit to Hospice Care.

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**Physician Signature**

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**Date**