HOSPICE REFERRAL FAX FORM

PLEASE FAX TO: (866) 682-6164 (monitored 24/7)
OFFICE PHONE: (404) 763-1456 (24/7)
Fax Referrals will be acknowledged within 30 minutes
If you DO NOT receive confirmation, please contact us at (404) 763-1456.

Referral Source's Phone (for confirmation callback): (_____) _____

Patient's Name: _____ DOB _____

Please evaluate and admit the patient to Agape Hospice Care if appropriate. (please initial one box only)

____ Please turn over care to the hospice Medical Director.

____ I will remain the attending physician for this patient.

____ I wish to remain the attending physician but place hospice care to the hospice medical director.

_____ _____
PHYSICIAN SIGNATURE DATE

_____
PHYSICIAN PRINTED NAME

Please include the following: H&P; Labs; Recent Patient Notes; any documentation to support the patient's terminal diagnosis.

Please provide any additional comments: _____

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