



## 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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