HOSPICE FAX
614-533-0087

OhioHealth

Referral Phone: 614-566-5377

PATIENT INFORMATION			
Patient's Name:			Date:
Address:			City, State, Zip:
Home Phone:			Cell Phone:
SS#:			DOB:
Medicare #:			Mcd#:
Insurance:	Policy #:		Group:
Secondary Contact:		Relationship:	Phone:

Please include current H&P & Progress notes

Patient Diagnosis: _____ Allergies: _____

Ordering Physician: _____ Phone: _____

Office Contact: _____

❑ **Please indicate if you would like a call to confirm that fax was received.**

PHYSICIAN COVERAGE

❑ **Remain attending** physician for patient. The best way to contact me is identified below.

Monday-Friday during regular business hours _____

Weekends and off-hours _____

❑ **Remain attending** physician (which includes receiving regular patient updates and death notifications) AND request the following **hospice physician consult services.**

- ❑ A hospice and palliative physician to cover all pain and symptom management issues.
- ❑ A hospice and palliative physician to manage only pain medication issues.

❑ I prefer to have an OhioHealth **Hospice physician become the attending physician**. I would still like to receive regular updates and death notification.

❑ I would like to speak to an OhioHealth Hospice physician for more details about services they can provide.

Physician signature: _____ Date:_____

CONFIDENTIALITY NOTICE