

HOSPICE FAX

614-533-0087



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: _____

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