

To complete this form online, visit www.hospiceofthepiedmont.org/referral-form



Referral Fax: **336.889.3450**
Referral Phone: 336.889.8446



Referral Fax: **336.450.1800**
Referral Phone: 336.672.9300

Patient Information

Patient Name: _____

DOB : _____ Last 4 of SSN : _____

Primary Diagnosis: _____

Primary contact: _____ Relationship: _____

Phone : _____

Provider Information

Referring Provider Name: _____

Choose one:

- 1) I will serve as the Hospice Attending Provider and manage all care.
- 2) I will serve as the Hospice Attending Provider but prefer the Hospice medical staff manage my patient's terminal diagnosis including symptom management, prescriptions, and in-home visits, if needed.
- 3) I will not serve as the Hospice Attending Provider and request that Hospice medical staff fulfill the role of Attending Provider and management of my patient's terminal diagnosis including symptom management, prescriptions, and in-home visits, if needed.

If your provider records are available through EPIC, no further patient documentation is needed. Otherwise, please fax any potentially helpful patient information, including:

- Demographics/ Face Sheet
- Provider's Notes (last 3 visits)

Contact Name: _____

Phone: _____ Date: _____

If unsure about a patient's hospice eligibility, please call our Admissions & Referrals team at 336-889-8446 to learn more about Care Connection, our home-based palliative care program.