FAX REFERRAL FORM
Phone: 206-749-7701 or 206-320-4000
Fax: 206-320-7333

Please use a cover sheet.
Please call our Intake Office at 206-749-7701 to confirm our receipt of your fax.
Our Intake Team will follow-up with your office for any other necessary information.

TODAY'S DATE___/____/____ **MD OFFICE CONTACT NAME**________________________ **PHONE# (   )**____________________

FAX# (   )________________________

REFERRAL INFORMATION

PATIENT'S NAME ______________________________ __________________________ _________
Last First MI

DOB______/______/_______ **SOCIAL SECURITY NUMBER** (if available)_________ – _______–__________

LANGUAGE PT SPEAKS____________________ (If not English)

INTERPRETOR NEEDED: YES NO If no, **name & phone** of person who speaks English_______________,(   )_______________

IS PATIENT COMPETENT TO SIGN CONSENT FOR HOSPICE CARE: YES NO **IF NO, LIST NAME OF DPOA ON NEXT LINE**

NEXT OF KIN NAME____ **RELATIONSHIP**______________________________

HOME# ____________________________ **WORK#**_____________________________ **CELL #**_____________________________

HOSPICE DIAGNOSIS____

ATTENDING PHYSICIAN (FOR HOSPICE CARE) __________________________________ **PHONE# (   )**____________________

Please fax the following information with this referral form (if available):

- ☐ Face Sheet (including name, address, insurance info)
- ☐ Copy of current medication list
- ☐ Recent H & P
- ☐ Hospital D/C Summary or recent office visit notes (to describe the patient's current clinical condition)
- ☐ Copy of physician's order for hospice care

Privileged and Confidential Communication: The information contained in this facsimile is privileged, confidential and otherwise exempt from disclosure and is intended solely for the use between the referral source and Providence Hospice of Seattle. If you have received this facsimile in error, please call 206-749-7701, immediately.