Transitions® HospiceCare

# Referral Fax 919-828-9514

For questions call Access Department: 919-828-0890

Date: _____

Number of Pages to follow: _____

## Please call our Access Department
## if you do not receive a call within 24 hrs.

Name of person completing this referral: _____

Patient: _____ Primary Diagnosis: _____
Required

Facility Name (print): _____

Facility Telephone: _____ Facility Fax: _____

Physician's name: _____

FAX IN:

- ☐ This sheet signed by physician
- ☐ H&P / FL2 / Hospital discharge summary
- ☐ Demographic Sheet / Face Sheet (include DOB, SS#, insurance information, responsible party)
- ☐ Medication list

Medicare requires a Certification of Terminal Illness from the attending physician (on reverse).

Transitions HospiceCare

Attending Physician Confirmation
& Certification of Terminal Illness
transitionslifecare.org

# PLEASE FAX TO 919-828-9514

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## *Time Sensitive*

**Medicare requires confirmation of the attending physician & Certification of Terminal Illness within 48 hours of admission to hospice care. Please sign and return this document via fax as soon as possible.**

**If you do not intend to serve as the attending physician for hospice services, please notify us by phone or fax right away. Thank you!**

**Patient Name:**_____
LAST FIRST MI

**Date of Birth:**_____ **Transitions HospiceCare ID:**_____

**Provider Name (Please Print):**_____

☐ I will continue to serve as this patient's attending physician. If I am unavailable, I give permission for orders for this patient to be obtained from an alternate physician/NP in my practice.

I certify to the best of my medical knowledge that this patient is terminally ill with a life expectancy of six (6) months or less if the terminal illness runs its normal course.
(Not applicable for Nurse Practitioner or Physician Assistant attendings)

A Transitions HospiceCare nurse or physician may release the body to a funeral home or crematorium at the time of death. I understand that Medicare requires that physician employees of Transitions HospiceCare may write orders for this patient to address unmet general medical needs.

or

☐ I would like a Transitions HospiceCare physician/NP to serve as the patient's attending physician.
(Not applicable for patients who reside in Skilled Nursing Facilities)

**Provider Signature:**_____ **Date:**_____