



At ABC Hospice, we serve our patients and family members with empathy, respect, compassion and integrity. We appreciate your referral to ABC Hospice.

ABC Hospice referral procedure:

- Fax physician's orders to ABC Hospice to evaluate and treat patient. Verbal orders are welcome, however handwritten physician orders must follow.
- An ABC Hospice admission nurse will make a home visit to assess the patient, and obtain the patient's signature for consent to release their medical records.
- An ABC Hospice nurse will fax the request for release of medical records to the office of the patient's physician.

Documents required from patient's physician:

- Diagnosis
- Recent H&P
- Recent labs
- Recent diagnostic studies
- Current list of medications

If qualifying criteria are met, the patient will be admitted to ABC Hospice. An ABC Hospice nurse will follow-up regarding patient admission.

LOCAL: 256-638-3491

TOLL FREE: 866-847-8660

FAX: 866-479-2227



ABC Hospice
INC.
A caring touch, a hand of compassion

Physician / Other / Name _____ UPIN _____

Address _____ City _____ State _____
Zip Code _____

Nurse / Contact Person _____ Phone (____) _____

PATIENT INFORMATION

Patient Name _____

Address _____ City _____ State _____

Zip Code _____

Home Phone _____ Alt. phone _____

Social Security # ____-____-____ Date of Birth ____/____/____ Male ____ Female ____

DIAGNOSIS- Prognosis of 6 months or less

____ COPD ____ Cancer ____ CHF ____ Alzheimer's ____ End-Stage Renal Failure
____ ALS ____ Parkinson's (end-stage) ____ Severe Debility Other _____

Please fax the following:

- Recent History and Physical
- Recent Labs & Diagnostic Studies
- List of current medications

Does referring physician want to palliate the patient? Yes / No (circle one)

Does referring physician wish for the Hospice Medical Director to palliate? Yes/ No (circle one)

PATIENT INSURANCE INFORMATION

Primary Insurance _____ Secondary _____

Policy # _____ Policy # _____

Group# _____ Group# _____

Phone # _____ Phone # _____

Name of Insured _____ Name of Insured _____

X _____
Physician Signature

Start Date