First Choice HOSPICE
1819 Virginia Avenue Harrisonburg, VA 22802
Phone: (540) 434-3916 * (800) 541-3398
Fax:(540) 432-0074

Hospice Referral Form

Please fax this form with History and Physical,
Diagnostic testing, Medication list and Labs
To (540) 432-0074

For referrals after hours and weekends, please call (540) 434-3916

Patient Name: _____ DOB: _____ Sex: F M

Patient Address: _____

Payor Source: _____ Patient Phone #: _____

Contact Person: _____Phone #: _____

Office Contact/Phone #: _____

Primary Dx: _____ Secondary Dx: _____

Orders: Check all that apply	
□	Assess for Hospice Eligibility
□	Admit to First Choice Hospice if appropriate
□	I wish to remain as Attending Physician
□	Hospice Physician to consult for pain and symptom management
□	Refer to Hospice Medical Director (Dr. G. W. Harper) to be Attending
□	I will sign the death certificate
□	Hospice Medical Director to be contacted after hours and weekends
□	I wish to be contacted for ALL needs at ALL times

Physician Signature: _____ Date: _____

Physician Printed Name: _____
