



Ph. (336) 331-1271
Fax (336) 499-0889

Serving 13 counties from 4 offices and an inpatient facility

•Cabarrus •Davidson •Davie •Forsyth •Guilford •Iredell •Rockingham •Rowan •Stanly •Stokes •Surry •Wilkes •Yadkin
•Kate B. Reynolds Hospice Home

To: <u>Trellis Referral Team</u>	From: _____
Fax #: <u>336-499-0889</u>	Fax #: _____
Ph #: <u>336-331-1271</u>	Ph #: _____
Email: <u>Admissions@TrellisSupport.org</u>	Date: _____

Please provide the information requested below via fax or email.

Physician request for patient assessment and admission to hospice services.

Attending physician certifies that to the best of their medical knowledge, this patient is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course.

Patient Name: _____ DOB: _____

Diagnosis/ICD-10 Code: _____

	Certifies the patient is terminally ill and agrees to follow as the patient's attending physician for hospice services.
_____ (Name of Physician)	
<input type="checkbox"/> Referring <u>physician</u> will NOT follow as hospice attending and Trellis medical providers can follow as hospice attending.	
<input type="checkbox"/> Patient in Skilled Nursing Facility is NOT utilizing Med A Days/ Insurance for Short Term Rehab or	
If in Rehab, provide End Date: _____	
<input type="checkbox"/> Patient is NOT receiving Home Health Services or	If receiving Home Health End Date: _____

Requested Documentation

To expedite the referral process, please provide the following documents if available.

- | | |
|--|---|
| <input type="checkbox"/> Demographic Information | <input type="checkbox"/> Consultation Reports |
| <input type="checkbox"/> Current Medication List (MAR/TAR) | <input type="checkbox"/> Laboratory Reports |
| <input type="checkbox"/> Physician notes | <input type="checkbox"/> Diagnostic Reports |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> H&P or D/C Summary from last hospitalization |

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