TRELLIS
Supportive Care

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:	Trellis Referral Team	From:	
Fax #:	336-499-0889	Fax #:	
Ph #:	336-331-1271	Ph #:	
Email:	Admissions@TrellisSupport.org	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)

☐ Referring physician will **NOT** follow as hospice attending and Trellis medical providers can follow as hospice attending.

☐ Patient in Skilled Nursing Facility is **NOT** utilizing Med A Days/ Insurance for Short Term Rehab or

If in Rehab, provide End Date: _____

☐ 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.

- ☐ Demographic Information
- ☐ Current Medication List (MAR/TAR)
- ☐ Physician notes
- ☐ History & Physical
- ☐ Consultation Reports
- ☐ Laboratory Reports
- ☐ Diagnostic Reports
- ☐ H&P or D/C Summary from last hospitalization

Revised: 4/24/26