



HOSPICE REFERRAL INTAKE FAX FORM

HOSPICE FAX REFERRALS: (503) 261-6080  
 HOSPICE PHONE REFERRALS: (503) 251-6192

PATIENT NAME:	DOB:	PHONE:
INSURANCE:		
REFERRING PHYSICIAN:	PRIMARY CARE PHYSICIAN:	
DIAGNOSIS:		
CONTACT NAME: (if different than patient)	PHONE:	
PLEASE SUBMIT THE FOLLOWING INFORMATION:		
Clinician Notes For The Past 6 Months Demographics Sheet		
PLEASE NOTE: You will be called by our hospice team within 24 hours to confirm this fax was received. Additional information may be requested depending on the terminal diagnosis.		

Thank you for choosing Adventist hospice for your patient's end of life care needs.