Transitions® HospiceCare

Founded as Hospice of Wake County • 1979

Referral Fax 919-828-9514

For questions call Access Department: 919-828-0890

Date: _____

Number of Pages to follow: _____

Please call our Access Department if you do not receive a call within 24 hrs.

Name of person completing this referral: _____

Patient: _____ Primary Diagnosis: _____
Required

Facility Name (print): _____

Facility Telephone: _____ Facility Fax: _____

Physician's name: _____

FAX IN:

- ☐ This sheet signed by physician
- ☐ H&P / FL2 / Hospital discharge summary
- ☐ Demographic Sheet / Face Sheet (include DOB, SS#, insurance information, responsible party)
- ☐ Medication list

Medicare requires a Certification of Terminal Illness from the attending physician (on reverse).

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Attending Physician
Certification of Terminal Illness
transitionslifecare.org

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FOR QUESTIONS PLEASE CALL: 919-828-0890

Time Sensitive

Medicare requires Certification of Terminal Illness from the attending physician within 48 hours of admission to hospice care. Please sign and return this document via fax as soon as possible.

If you do not intend to serve as the attending physician for hospice services, please notify us by phone or fax right away. Thank you!

Patient Name:_____
LAST FIRST MI

Date of Birth:_____ **Transitions HospiceCare ID:**_____

Physician Name (Please Print):_____

☐ I will continue to serve as this patient's attending physician. If I am unavailable, I give permission for orders for this patient to be obtained from an alternate physician/NP in my practice.

or

☐ I would like a Transitions HospiceCare physician/NP to serve as the patient's attending physician. (Not applicable for patients who reside in Skilled Nursing Facilities)

A Transitions HospiceCare nurse or physician may release the body to a funeral home or crematorium at the time of death. I understand that Medicare requires that physician employees of Transitions HospiceCare may write orders for this patient to address unmet general medical needs.

I certify to the best of my medical knowledge that this patient is terminally ill with a life expectancy of six (6) months or less if the terminal illness runs its normal course.

Physician Signature:_____ **Date:**_____

(Please Note: Certification of Terminal Illness must be provided by an MD or DO)