FAST TRACK REFERRAL FORM

Fax back to ***704.335.3522*** *with your cover sheet.*

If this is an ***URGENT*** *referral please call* ***704.375.0100*** *to let us know.*

REQUIRED INFORMATION

Is this a hospice or palliative care referral? ***Check one:***	Is the family/responsible party aware of this referral? ***Check one:***
Hospice ☐ **Palliative Care** ☐	**Yes** ☐ **No** ☐

PATIENT NAME: ______________________________

GENDER: ____ M ____ F DATE OF BIRTH: ____/____/____

RESPONSIBLE PARTY NAME: ______________________________

RESPONSIBLE PARTY PHONE #: ______________________________

PRIMARY DIAGNOSIS: ______________________________

SECONDARY DIAGNOSIS: ______________________________

AGENCY NAME: ______________________________

AGENCY CONTACT NAME: ______________________________

REFERRAL CONTACT PHONE #: ______________________________

SUPPORTING INFORMATION

If you have the following supporting documentation, please check off and provide by attaching to this fax:

- ☐ Patient face sheet (demographics)
- ☐ Last visit note
- ☐ History and physical
- ☐ Medicare/Medicaid/commercial insurance card
- ☐ Other

Notes documenting patient decline: ______________________________

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We look forward to serving you and your patients.

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