CARDINAL
HOSPICE CARE

REFERRAL FORM

Instructions:	Please fax or securely scan the information below along with any additional demographics, H/P, DC Summaries, and medical documentation as appropriate. We will forward to the physician for signature.
Send Via:	**referrals@cardinalhospicecare.com -or- Referral Fax: 910-989-2691**
Response Time:	If you have not heard from us within 30-minutes during normal business hours, please give us a call to verify receipt. For urgent referrals sent after business hours, please call our toll-free number and the on-call team will assist you as soon as possible.

Patient Name:_____ DOB: _____

Phone:_____ Date of Last Physician Visit: _____

Attending Physician/PCP:_____ Phone: _____

Primary Insurance & Number: _____

Primary Diagnosis Associated with Referral: _____

Referral Provider Name:_____ Referral Provider Phone: _____

ADDITIONAL INFORMATION:

_____

_____

FOR PHYSICIAN USE ONLY

Physician Order:
Please evaluate and admit to hospice services if appropriate.

Additional Orders: _____

_____

_____

Physician Name:_____ Date: _____

Physician Signature:_____