# QUICK FAX REFERRAL

PHONE: 678.583.0717
FAX: 770.727.0202
Lic # 060-0459-H/038-0446-H/075-176-H

☐ HOME ☐ GIP

## PATIENT INFORMATION

PATIENT NAME: ______________________ ATTENDING PHYSICIAN: ______________________

PATIENT LOCATION: ______________________ ROOM#: __________ BED#: __________

PATIENT IS AWARE OF REFERRAL
☐ YES ☐ NO

FAMILY IS AWARE OF REFERRAL
☐ YES ☐ NO

RESPONSIBLE PARTY AND/OR POA INFORMATION
NAME: ______________________ RELATIONSHIP: ______________________

PHONE: ______________________

PLEASE INDICATE YOUR PREFERENCE:

☐ Send a Sacred Journey representative to collect the necessary referral documentation

☐ Please call me to get the remaining referral information

☐ I have faxed a face sheet and applicable documentation to complete the referral including H&P, labs, discharge summary, orders and other pertinent information

☐ **HOSPICE REFERRAL:** Evaluate for hospice care and admit if eligible

COMMENTS: ______________________________________________
______________________________________________
______________________________________________

PHYSICIAN'S SIGNATURE: ______________________ DATE: ___ / ___ / ___

PERSON SENDING REFERRAL: ______________________ PHONE: ______________

ORGANIZATION: ______________________

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