

Hospice of the Upstate, Inc
1835 Rogers Rd, Anderson, SC 29621



REFERRAL FORM

Fax (864) 328-1132
Phone (864) 224-3358

REFERRAL TAKEN BY: _____ **Date:** _____ **Time:** _____

REFERRAL MADE FOR: **Hospice Home Care** **Hospice House**

REFERRAL SOURCE INFORMATION:

Organization Name: _____

Referred By: _____ Title: _____ Phone # _____

REFERRING PHYSICIAN:

Physician's Name: _____

Attending Physician's Name: _____

PATIENT INFORMATION:

Name: _____ SS# _____

Birth Date: _____ Sex: _____ Phone # (H) _____ (C) _____

REFERRING DIAGNOSIS:

Diagnosis: _____

PRIMARY CAREGIVER:

Name: _____ Ph# (H) _____ (C) _____

INSURANCE INFORMATION:

Medicare # _____ Medicaid # _____

Private Insurance:

Name of Insurance Company: _____

Policy # _____ Group Name: _____