Kansas City Hospice

& PALLIATIVE CARE

Request for Patient Services
Referral Line: 816.276.2700
Fax: 816.444.1928

Patient Name _____ DOB_____

Intake Coordinator _____ Contact # _____

Primary Diagnosis Code: _____

Attending Physician: _____ Referring Physician _____

If CARDIAC PATIENT, Cardiologist to follow for cardiac symptoms _____

Physician's Order for Service (check one)

☐ **Hospice Service** with Kansas City Hospice & Palliative Care.
Skilled nursing to evaluate and treat if appropriate.

☐ **Palliative Care Service** with Kansas City Hospice & Palliative Care.
Skilled nursing to evaluate and treat if appropriate.

➔ **Please fax the following to 816.444.1928:**

❶ **This form, with physician signature**

❷ **History & Physical, Discharge Summary and Discharge Orders**

❸ **Face sheet, or other document with DOB, SSN, address, insurance, primary contact**

❹ **Current medication list**

❺ **Medicare Part D information or copy of card (if available)**

Physician Signature _____ Date _____
(Unless orders are attached, a signature here will authorize services)

Thank you!