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:

Evaluate and Treat for All Palliative Services*
With Kansas City Hospice and Palliative Care

Please fax the following to 816.444.1928:

1. This form with physician signature
2. History & Physical, Discharge Summary and Discharge Orders
3. Face sheet, or other document with DOB, SSN, address, insurance, primary contact
4. Current medication list
5. Medicare Part D information or copy of card (if available)

Physician Signature _____ **Date** _____
(A signature here will authorize services)

Thank you!

All Palliative Care Services includes:

- Community Based Palliative Care @ home, LTC, IL, AL & Memory Care
- Hospice Care @ home, LTC, IL, AL & Memory Care
- North Care Hospice House for Respite or GIP
- KC Hospice House for Respite or GIP