



## ISLAND HOSPICE TRANSFER FAX COVER SHEET

### Patient Information

_____ Name	_____ Date of Birth
_____ Address	_____ City/State/ZIP
_____ SSN	_____ Medicare #
_____ Date	_____ Date of Transfer

### Transfer Agreement

\_\_\_\_\_ agrees to transfer to the services of

Patient \_\_\_\_\_

Hospice \_\_\_\_\_

_____ Patient/Patient Representative Signature	_____ Date
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### Instructions

Complete this form, then send it with a face sheet and the completed hospice discharge summary covering the following details:

1. Summary of the patient's care including treatments, symptom and pain management
2. Current plan of care
3. Most recent physician's orders
4. Any other data that will support continuity of care for the patient
5. If transfer occurs in the third election period of later, include F2F documentation

_____ Completed By	_____ Date
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### FOR OFFICE USE ONLY

Faxed  
  Mailed  
  Emailed on \_\_\_\_\_  
 Initials: \_\_\_\_\_