



HOW TO REFER YOUR PATIENT

Patient Name: _____

DOB: _____

Phone # _____

Person to contact to schedule a visit (if not the patient): _____

Relationship to Patient: _____

Phone # _____

Referring Physician Name: _____

Phone # _____

Referring Physician Name _____

Why are you making the referral?:

The following is a checklist of paperwork required to complete the referral process:

- Demographic information (address, insurance, SS#, etc.)
- History and physical or discharge summary from recent hospital stay or clinical notes
- Medication List

Please fax this form with the above documentation to our Access Department at (207) 289-3685, or you can give the above information to our nurse who sees patients at your facility.

If you have any questions, please call our Access Department at (207) 289-3649 or toll free (866) 621-7600.

1/8/2015



MAIN OFFICE:
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