without regrets

PHYSICIAN REFERRAL FORM

This form must be completed and signed by a licensed doctor of medicine who has direct knowledge of the client's medical condition and returned to the address below.

Patient Name:_____

Patient's Address:_____

Patient's Phone:_____

Patient's E-mail: _____

Patient's Qualifying Condition:_____

Patient's Physician:_____

Physician Phone:_____Physician NPI:_____

Physician Fax:_____Physician e-mail:_____

I am familiar with this patient and their physical condition. I certify that at the time of referral the patient has been diagnosed with a terminal or progressive end stage illness, has limited life expectancy and that all of this patient's children are aged 18 and under. (Note: We will contact you if there are any questions regarding the patient's eligibility.)

Please explain the patient's diagnosis and prognosis:_____
_____
_____
_____

May travel by car: ☐ Yes ☐ No
May travel by plane: ☐ Yes ☐ No
Activity Level: ☐ No limitations ☐ Moderate ☐ Sedentary
Max duration of travel allowed (if less than 5 nights or if limited to hours allowed en route):_____
Requires ADA room: ☐ Yes ☐ No
Other limitations and special needs:_____

_____ _____
Physician's Signature Date

Please return this form via email to:
Without Regrets Foundation
Referrals@withoutregrets.org