



# PATIENT REFERRAL FORM

If you have a patient who might benefit from hospice services, please complete and return this form. A hospice specialist will follow up promptly.

**PATIENT**

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Patient Telephone #: \_\_\_\_\_

Alternative Contact Name: \_\_\_\_\_ Contact #: \_\_\_\_\_

Who should we contact to discuss our services:  Patient  Alternative Contact

Primary Physician Name: \_\_\_\_\_ Primary Physician Fax: \_\_\_\_\_

Most recent visit:  Office  Telehealth Date last seen by physician: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Insurance Information: \_\_\_\_\_

## HOSPICE ORDERS

**Patient's Primary Diagnosis and reason the patient requires hospice care:**

\_\_\_\_\_

**Please send the supportive documentation below with the order:**

- ⇒ Demographics
- ⇒ History and Physical
- ⇒ MARS
- ⇒ Labs/COVID-19 test results
- ⇒ Last visit notes

## GENERAL CRITERIA INDICATORS

**Please select all that apply (Optional):**

- |  |   |
|--|---|
| <input type="checkbox"/> Increased assistance in ADLs        | <input type="checkbox"/> Altered mental status            |
| <input type="checkbox"/> Multiple ER visits/hospitalizations | <input type="checkbox"/> Multiple falls                   |
| <input type="checkbox"/> Unintentional weight loss           | <input type="checkbox"/> Skin breakdown                   |
| <input type="checkbox"/> Increasing shortness of breath      | <input type="checkbox"/> Recurrent or multiple infections |
| <input type="checkbox"/> Frequent medication changes         |   |

Recent decline in condition(s) to note:

\_\_\_\_\_

**For physicians: please sign here to authorize us to evaluate and admit patient, if eligible.**

Physician's Name (Please Print): \_\_\_\_\_ Physician Phone: \_\_\_\_\_

**Physician's Signature:** \_\_\_\_\_ Signature Date: \_\_\_\_\_

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