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):

☐ Increased assistance in ADLs
☐ Multiple ER visits/hospitalizations
☐ Unintentional weight loss
☐ Increasing shortness of breath
☐ Frequent medication changes
☐ Altered mental status
☐ Multiple falls
☐ Skin breakdown
☐ Recurrent or multiple infections

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: _____