

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: <input type="checkbox"/> Patient <input type="checkbox"/> Alternative Contact
	Primary Physician Name: _____ Primary Physician Fax: _____
	Most recent visit: <input type="checkbox"/> Office <input type="checkbox"/> 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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