Hospice Referral Form

TEL: 248-352-3400 FAX: 248-352-2995

URGENT ☐ within 24 hours priority collaboration

REFERRAL SOURCE

Date/Time of Referral _____ Referrer _____ Tel # _____

Source: Hospital/SNF (Name/Unit #) _____

☐ MD ☐ PT/FAM ☐ Other MRN # _____

PATIENT INFORMATION

Patient Name _____ Gender ☐ M ☐ F Language Spoken _____

Address _____ Tel # _____

_____

DOB _____ Age _____ SS # _____ Marital Status ☐ Married ☐ Single

Lives ☐ Alone ☐ With Family ☐ with Spouse ☐ with FES ☐ in SNF ☐ Divorced ☐ Widowed

Primary Contact _____ Home Tel # _____

Relationship _____ Office Tel # _____

Address _____ Cell # _____

_____

Health Care Proxy/Surrogate _____ Home Tel # _____

Relationship _____ Office Tel # _____

Address _____ Cell # _____

_____

CLINICAL

Terminal Dx _____ Dx _____

IV _____ Mediport Access _____ Allergies _____

INSURANCE

Primary Insurance _____ # _____ Verified ☐ Pending ☐ Done

Other Insurance _____ # _____ Auth # _____

Insurance Contact Person _____ Tel # _____ Auth. Period _____

PHYSICIAN

Primary MD _____ License # _____

Mailing Address _____ Tel # _____ Fax # _____

_____

Is MD willing to continue providing care to the patient while on hospice? ☐ Yes ☐ No

HOSPICE REFERRAL / VERBAL ORDER

I am referring this patient for hospice care. Patient competent to sign consents? ☐ Yes ☐ No

Physician Signature _____ NPI # _____ Date _____

OTHER

Patient/Family aware of Hospice referral ☐ Yes ☐ No Patient served in the military? ☐ Yes ☐ No

COMMENTS "Why Hospice Now?" Describe patient decline that precipitated Hospice (comment below)

_____

_____

_____