

URGENT within 24 hours priority collaboration

SC# _____ **Case#** _____

REFERRAL SOURCE

Date/Time of Referral _____ Referrer _____ Tel # _____

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

MD PT/FAM Other Adult Care Team # _____ 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)

