Hospice Referral
Please Fax to 660-627-7005
Or call 660-627-9711

REFERRAL SOURCE

Date/Time of Referral ____________________ Referrer ________________________ Contact # ________________

Source: Hospital/SNF/Physician ____

PATIENT INFORMATION

Patient Name ____ DOB _________________________________

Address ______________________________________ City ____________________ County __________________

Phone __________________________ SSN ___________________________ Gender: ☐ Male ☐ Female

Marital Status _______________________________________

Family/Caregiver Contact ____ Phone _________________________

Relationship ____ ☐ DPOA ☐ Legal Guardian

INSURANCE

☐ Medicare # _______________________________________ ☐ Medicaid # ______________________________

☐ Primary Insurance/Medicare Replacement ____

ID# ____________________________ Policy # ________________________ Group # ____________________

PHYSICIAN

Referring Physician ____ Phone _________________________

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

CLINICAL

Terminal Dx ____ Other Dx ____________________________________

Why Hospice Now? Describe patient decline that precipitated Hospice (comment below or include in referral information)

____

____

OTHER

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

DME Needs ____

REFERRAL / VERBAL ORDER

☐ **Evaluate and admit to hospice, if eligible. Diagnosis and prognosis of 6 months or less if disease runs its normal course.**

_______________________________________ _______________________________________

Provider Signature Date

_______________________________________ _______________________________________

Provider Name NPI

<u>Please fax the following documents with this referral:</u> ☐ **Demographic/Face Sheet** ☐ **Copy of Insurance Cards** ☐ **H&P** ☐ **Progress Notes** ☐ **Diagnostic/Lab/Path reports** ☐ **Any other documentation to support terminal status**