Hospice and Palliative Care

Hospice Referral Form

TEL: 212-609-1900 FAX: 212-290-1825

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)

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