



**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)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_