Life Hospice Patient Referral Form

Patient Information

Patient Name: _________________________________ dob: / / gender: male ☐ female ☐ other ☐

Patient Address: ____________________________________ City: _______________ State: ___ Zip: _______

Patient contact number: _________________________ Patient email: ________________________________

Secondary contact:_______ ____________________ Contact phone: _______________________________

Relationship to patient: _________________________ email: ______________________________________

Has hospice been discussed with patient/family: Yes No (circle as appropriate)

Who should we contact to discuss care: patient ☐ secondary contact ☐

Attending Physician: ____ Primary Hospice Dx:_______________

Referral Contact Name: ______________________ Contact Phone:__________________________________

Referral Fax: ________________________ Referral Email: ____

Clinical Documentation

Please supply any/all supporting documentation:

- Face sheet (demographics)
- History and Physical
- Recent visit notes
- Pathology Reports
- Discharge documents
- Lab reports
- Insurance Information (copy of cards if available)
- Comments on update status and/or oncerns:____

  ____

Orders

☐ Evaluate and Treat to Hospice Services

Please choose from below options:

☐ Hospice Medical Director to assume care of patient.

☐ Dr.________________________________ to remain attending physician.

☐ Dr.________________________________ will remain attending physician with hospice medical director to assist with symptom management.

DME orders:

☐ hospital bed

☐ commode

☐ oxygen

☐ wheelchair

☐ walker

☐ app

☐ other

Additional Orders: ____

Physician Signature: ____

Physician Name (print)____ Date:____________

Physician NPI:_______________________________________ Fax number: __________________________

Fax/email form and documents to:

Michele Smith | Life Hospice

973.607.4401

MicheleSmith@hospicecare.life