FAX TO: 559.388.5258
TEL: 559.431.3333
VALLEYREGIONALCARE.COM

HOSPICE REFERRAL FORM

REFERRAL SOURCE

Date/time of referral ______________ Referrer ______________________________ Telephone number _________________________

Source name ____ ☐ MD ☐ Hospital ☐ SNF ☐ Other

PATIENT INFORMATION

Name ____ Gender ☐ Male ☐ Female Language _________________________

Address ____ Phone number ________________________

DOB ______________ Age ________ SS# ____________________________ Marital Status ☐ Married ☐ Divorced

Lives ☐ Alone ☐ With Family ☐ With spouse ☐ With FES ☐ In SNF ☐ Single ☐ Widowed

Primary contact ____ Home phone _____________________________

Address ____ Cell phone _______________________________

Preferred contact ☐ Home ☐ Cell

Health care proxy (if applicable) ____ Home phone _____________________________

Relationship to patient ____ Cell phone _______________________________

Address ____ Preferred contact ☐ Home ☐ Cell

CLINICAL INFORMATION

Terminal DX ____ Secondary DX ____

IV ______________ Mediport access ______________________________ Allergies _______________________________________

INSURANCE INFORMATION

Primary insurance ____ Copies of insurance, Social Security and

Other insurance ____ government-issued ID included ☐ Yes ☐ No

PHYSICIAN INFORMATION

Primary MD ____ License # ________________________________

Mailing address ____ Phone number ____________________________

Willing/planning to continue providing care while patient is on hospice? ☐ Yes ☐ No Fax number ______________________________

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?" Please describe patient decline that precipitated hospice ____

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