Crossroads House

END-OF-LIFE DOULA REFERRAL FORM

Referring Individual _____ **Date** _____

Address _____ **Phone** _____

Client Information

Client Name _____ **Address** _____

Date of birth _____ **Current Placement** _____

Diagnosis _____

Prognosis of 3 months or less? ☐ **Yes** ☐ **No**

Is client currently under Hospice, VNA or HCR? ☐ **Yes** ☐ **No**

Is client aware of prognosis? ☐ **Yes** ☐ **No**

Any other import information that you wish to discuss? _____

_____

_____

_____

I understand that this does not guarantee a Crossroads House End-of-Life Doula in my home. An assessment must be done, and client must be deemed appropriate. The Director of Doula Services will call you within 24 hours of referral completion.

Thank you.

Crossroads House