Central Valley Hospice Palliative Medicine

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HOSPICE REFERRAL/PHYSICIANS ORDER

Patient name: _____ D.O.B: _____

Address: _____ SSN: _____

Contact phone: _____ Contact e-mail: _____

Patient representative (if applicable): _____ Relationship: _____

Primary Health Insurance: ☐ Medicare ☐ Medi-Cal ☐ Other: _____

Member ID: _____ Group: ___

EVALUATION / ADMIT INFORMATION

Ordering Physician (printed name): _____

Alternate Contact / Office Contact (printed name): _____

Contact Phone: _____ Fax:_____

☒ Please evaluate for Hospice and admit as appropriate.

Attending Physician's order for Hospice Services and Certification of Terminal illness:

- ☐ Terminal Diagnosis: _____
- ☐ Secondary Diagnosis: _____
- ☐ I certify that this patient is under my care and to the best of my medical knowledge, given the data available, that this patient is terminally ill with the expectancy of six months or less if the terminal illness runs its normal course.

Physician's Signature: _____ Date: _____

- ☐ *I wish to follow the patient and be contacted directly for all orders and changes in condition. Should the need arise for a change in the current plan of care the Hospice Physician can be designated in my absence. I wish to sign the Death Certificate. The Hospice Physician may follow and support pain and symptom management.*
- ☐ *I do not wish to follow patient and/or sign the death certificate. Please assign hospice medical director to follow.*

PLEASE ATTACH THE FOLLOWING DOCUMENTS WITH THIS REFERRAL:

Primary Point of Contact and phone number for scheduling:
Patient demographic sheet
Copy of insurance card (if available)
History & Physical
Diagnostic reports (CT, MRI, PET scan, lab tests, biopsy, x-ray, etc)
Recent hospital records (if available)
Physician progress notes
Height/Weight