HOSPICE REFERRAL & MD FORM

FROM (Name) (Phone) **PATIENT LOCATION**

FAX TO ANX Intake Department **OUR FAX NO.** (650) 991-1107

PLEASE INCLUDE THE FOLLOWING:

- ❑ Face Sheet/Demographics
  (If not attached, complete Patient Information)
- ❑ History & Physical
- ❑ Recent Consultation Reports/Labs
- ❑ Discharge Orders
- ❑ Progress Notes
- ❑ Current Medication List
- ❑ POLST
- ❑ Physician Report (602)
  (for RCFE patient)
- ❑ Attending MD to evaluate/admit:

PATIENT INFORMATION:

PATIENT NAME:

DOB: ❑ M ❑ F SSN:

INSURANCE: *Include copies of insurance card*

CARE TO BE PROVIDED AT ❑ Home ❑ RCFE ❑ SNF*

**SNF contract in place?* ❑ Yes ❑ No

RESPONSIBLE PARTY/DPOA NAME:

PHONE NUMBER: EMAIL (REQUIRED):

( )

SERVICES REQUESTED (Check all that apply):

- ❑ Educational/Informational Meeting
- ❑ Urgent Admission
- ❑ Admit per Patient Preference
- ❑ Other_____

CLINICAL INFORMATION

TERMINAL DIAGNOSIS:

OTHER DIAGNOSIS

- ❑ Diabetes: ____Insulin Dependent ___Non-Insulin Dependent
- ❑ Cancer_____: ___Metastatic ___Active Chemotherapy ___Active Radiation Therapy
- ❑ CHF
- ❑ COPD
- ❑ HIV/AIDS
- ❑ Renal Failure
- ❑ Stroke/Coma
- ❑ Alzheimer's/ Dementia
- ❑ Parkinson's/Neuro
- ❑ Chronic Wounds/Ulcers

Patient is on:

- ❑ Feeding tube ❑ Catheter
- ❑ Drain ❑ IV

MEDICAL EQUIPMENT NEEDS:

- ❑ Oxygen at ___L/min via ☐ NC ☐ Mask ☐ Continuously ☐ Intermittent
- ❑ Hospital Bed ☐ Half Rails ☐ Full Rails
- ❑ Bedside Commode
- ❑ Bedside Table
- ❑ Wheelchair
- ❑ Mattress ☐ LAL ☐ PRM
- ❑ Bipap
- ❑ Cpa

Please evaluate and admit under Hospice:

_____ _____/_____

PHYSICIAN NAME PHYSICIAN SIGNATURE DATE

To expedite admission, call/text your Account Executive to confirm receipt. Thank you for your referral!