COMFORT CHOICE
HOSPICE CARE

PATIENT REFERRAL FORM

REQUESTED START OF CARE DATE

(MM/DD/YY): _____

PATIENT NAME: _____

PHONE: _____

GENDER: □ MALE □ FEMALE

MEDICARE #: _____

REFERRAL SOURCE (DOCTOR/FACILITY):

_____

CONTACT NAME: _____

DATE: _____

FAX: _____

PHONE: _____

TOTAL # OF PAGES: _____

REASON FOR HOSPICE REFERRAL: _____

DIAGNOSIS: _____

□ EVALUATE AND ADMIT AS APPROPRIATE

□ I WILL FOLLOW MY PATIENT AS AN ATTENDING PHYSICIAN WHILE THEY ARE UNDER HOSPICE CARE

□ PT IS A DNR _____

OTHER ORDERS/SPECIAL NEEDS:

_____

_____

_____

SIGNATURE: _____ **DATE: _____**

PRINTED NAME: _____

FORM COMPLETED BY: _____ **DATE: _____**

THANK YOU FOR YOUR REFERRAL! PLEASE ATTACH THESE ESSENTIAL DOCUMENTS BEFORE FAXING:

□ FACT SHEET
□ COPY OF INSURANCE CARD
□ MED LIST
□ H&P

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