

# HOSPICE REFERRAL



Date: \_\_\_\_\_ Time: \_\_\_\_\_

PORTLAND OFFICE      SALEM OFFICE  
ph: 503.639.0600      ph: 503.991.5228  
fax: 503.639.0699      fax: 503.715.1287  
877-297-2442 after hours

Serenity Hospice is available to take patient referrals by phone 24 hours a day, 7 days a week.  
If it is easier for you to provide this information via phone, please call us.

## REFERRAL INFORMATION

Patient Name: \_\_\_\_\_

Attending Physician: \_\_\_\_\_

Referral Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Insurance Info: \_\_\_\_\_ Medicare Number: \_\_\_\_\_

Hospice evaluation and admission if appropriate. Prognosis is 6 months or less if disease takes usual/expected course.  Yes  No

Terminal Diagnosis: \_\_\_\_\_

Attending Physician will continue to manage care while patient is on hospice.  Yes  No

If yes, Hospice Medical Director to manage palliative needs if I am unavailable.  Yes  No

Physician Signature (must be MD or DO): \_\_\_\_\_

## PATIENT INFORMATION

Is Patient in a facility?  Yes  No      Name of Facility: \_\_\_\_\_

SSN: \_\_\_\_\_      DOB: \_\_\_\_\_      Previous Hospice Patient?  Yes  No      Discharge Date: \_\_\_\_\_

Home Health?  Yes  No      Skilled Bed?  Yes  No      Admit Urgent?  Yes  No

Equipment Needed: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## PLEASE INCLUDE:

Face Sheet       History & Physical       POLST       Medication List

Visit notes related to terminal illness (as appropriate)       Relevant progress/lab/hospitalization notes

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Total number of pages, including cover sheet: \_\_\_\_\_

FAX TO PORTLAND OFFICE: **503.639.0699** or SALEM OFFICE: **503.715.1287**