

HOSPICE REFERRAL



Date: _____ Time: _____

ph: 503.639.0600
toll-free fax: 855.279.6101
www.serenityhospice.org

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 TOLL-FREE TO: **855.279.6101**