Hospice of Hope

Hospice Referral

Please complete and FAX this form to 901-756-7085. A hospice intake coordinator will follow up.

Patient Information

Patient Name: ____

DOB: ______________ SSN: ________________ Race: ________ Sex: ______

Type of Residence: ☐ Home ☐ Nursing Home ☐ Assisted Living ☐ Group Home ☐ Other: ________

Address: ________________ City: ____________ State: ________ Zip: ______

Patient's Phone Number: ______________ Caregiver's Phone Number: ________________

Referral Contact Name: ______________ Contact Phone Number: ________________

Attending Physician: ________________ Contact Phone Number: ________________

Primary Hospice Diagnosis: ____

Secondary Diagnosis: ____

Has patient and/or family informed about hospice admission? ☐ Yes ☐ No

☐ The following documents are attached (fax) to this referral ☐ Prefer Hospice Representative pick up documents

- ☐ Patient Face Sheet
- ☐ Medicare/Medicaid/Commercial Insurance Card
- ☐ History & Physical
- ☐ Labs
- ☐ Discharge Summary
- ☐ Pathology Reports

Payment Source

MCA: ________________________ MCD: ________________________

Insurance Company: ________________________ Phone: ______________

Policy Number: ________________________ Group Number: ______________

Orders

☐ Evaluate and Admit into Hospice.

Please choose one box below:

☐ Hospice Medical Director to assume care of the patient.

☐ Dr. ______________ will remain attending physician.

☐ Dr. ______________ will remain attending physician with Hospice Medical Director to assist with signs and symptoms management.

Physicians: Please sign to authorize Hospice of Hope to evaluate and admit the patient, if eligible for hospice.

Physician Signature: ________________________ Date: ______________

Physician Name (Print): ________________________

Thank you for the opportunity to care for your patients.