

HOSPICE REFERRAL FORM

8797 Beverly Blvd., Suite 310w. Hollywood, CA- 90048
Phone: 323-653-0544



Patient Name	Height	Weight	Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Patient Address				
Patient Phone	Alternate Patient Phone	DPOA/Primary Contact Name	DPOA/Primary Contact Phone	
Medicare #	Medical #	Secondary Insurance	Social Security #	
<input type="checkbox"/> Evaluate for Hospice and Admit Patient Location: <input type="checkbox"/> Home <input type="checkbox"/> RCFE <input type="checkbox"/> SNF <input type="checkbox"/> ALF DME: <input type="checkbox"/> Wheelchair <input type="checkbox"/> Hospital Bed <input type="checkbox"/> Oxygen <input type="checkbox"/> Hoyer Lift <input type="checkbox"/> Other: _____ DNR: <input type="checkbox"/> YES Advanced Directive: <input type="checkbox"/> YES <input type="checkbox"/> NO				

PHYSICIAN'S CERTIFICATION FOR MEDICARE HOSPICE BENEFIT

- I certify that this patient is terminally ill with a life expectancy of six (6) months or less if the terminal runs its normal course. I have reviewed the patient's clinical information and considered the primary terminal condition, related diagnoses, current subjective and objective medical findings, current medication and treatment orders and information about management of unrelated conditions in making this determination.
- The following medical disease or terminal diagnosis is the primary reason for hospice care:
☐ Cancer ☐ COPD ☐ End Stage Heart Disease ☐ Alzheimer's / Dementia ☐ Stroke / CVA ☐ End-Stage Renal Disease
☐ Failure to Thrive ☐ General Debility ☐ Other: _____
- Co-Morbidities for Hospice Appropriateness are:
☐ Multiple ER visits or hospitalization, or emergency room visits more than once in the past six (6) months
☐ Multiple medications
☐ Increasing shortness of breath even while resting
☐ Multiple falls or several falls over the last six (6) months
☐ Increased assistance with ADLs
☐ Skin integrity/breakdown or starting to spend most of the day in chair or bed
☐ Recurrent/multiple infections
☐ Weight loss or weight loss with a noticeable difference in the way clothes fit
☐ Altered mental status
☐ Started feeling weaker or more tired than usual
☐ Been making more frequent phone calls to physician's office
☐ Other: _____

Choose One: ☐ I DO want to follow this patient ☐ I DO NOT wish to follow this patient; please have hospice medical director follow

Referring Physician		NPI #
Physician Address	Physician Phone #	Physician Fax #
Physician Signature		Date