# Valley Regional Hospice Referral Form

Tel: 559-431-3333 Fax: 559-431-9777

**REFERRAL SOURCE**

Date/Time of Referral_____ Referrer_____ Tel #_____

Source: Name_____ □ MD □ Hospital □ SNF □ Other

**PATIENT INFORMATION**

**Name**_____ Gender □ M □ F Language_____

Address_____ Tel #_____

_____

DOB _____ Age _____ SS# _____ Marital Status □Married □Divorced

Lives: □ Alone □ with Family □ with Spouse □ with FES □ in SNF □Single □Widowed

**Primary Contact**_____

Relationship to Patient_____ Home #_____

Address_____ Cell #_____

_____ Best # for contact □ Home □ Cell

**Health Care Proxy** (if applicable)_____

Relationship to Patient_____ Home #_____

Address_____ Cell #_____

_____ Best # for contact □ Home □ Cell

**CLINICAL INFORMATION**

Terminal Dx_____ Secondary Dx _____

IV_____ Mediport Access_____ Allergies_____

**INSURANCE INFORMATION**

Primary Insurance_____ Copies of Insurance, SS, □ Yes

Other Insurance_____ & Gov't issue ID included □ No

**PHYSICIAN INFORMATION**

**Primary MD**_____ License #_____

Mailing Address_____ Tel #_____

_____ Fax #_____

Is MD willing/planning to continue providing care while patient is on hospice? □ Yes □ No

**HOSPICE REFERRAL/VERBAL ORDER**

□ I am referring this patient for hospice care. Patient competent to sign consents? □ Yes □ No

Physician Signature_____ NPI#_____ Date_____

**OTHER**

Patient/family aware of hospice referral? □ Yes □ No Patient served in the military? □Yes □No

**COMMENTS** "Why hospice now?" Please describe patient decline that precipitated hospice. (comment below)

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