PeaceHealth

PeaceHealth Hospice Referral Form

Intake Phone: **360-696-5100**
Intake Fax: **360-696-5038**

Date: ____________________

Patient Name: ____________________

Patient Address: ____________________

City: ____________________ Zip Code: ____________________

Patient Phone Number: ____________________

Date of Birth: ____________________ Age: ____________________

Primary Contact Person: ____________________

Contact phone number: ____________________

Hospice Diagnosis: ____________________

____

Attending Physician: ____________________

Referral Contact Name: ____________________

Referral Contact Phone Number: ____________________

Order Instructions:

- ☐ Hospice Consult Meeting Only
- ☐ Evaluate and admit to hospice if appropriate. Initial certification indicates that patient has a terminal illness with life ex-pectancy of six months or less if disease should run its normal course.
- ☐ Urgent Admit
- ☐ Other Orders: ____________________

Ordering Provider Signature: ____________________ Date: ____________________

Ordering Provider Printed Name: ____________________

Please provide the following supporting documents with this referral: (all boxes must be checked):

- ☐ **Patient Face Sheet or demographics**
- ☐ **Current medication list**
- ☐ **Pathology, diagnostic/imaging and lab reports related to hospice diagnosis**
- ☐ **Most recent history and physical**
- ☐ **Copy of Payer/Insurance Card**