BY YOUR SIDE
HOSPICE CARE

FAST TRACK HOSPICE REFERRAL

COMPLETE THIS FORM AND FAX TO 888-463-0001. QUESTIONS? CALL 414-662-7701

☐ **URGENT**

Date: ____/___/____ Time: ___ Referrer Source: _____________Contact Name: ___________ Phone No.______________

Patient Name: _________________________________ Gender: M____ F ____ Date of Birth: ______/___/________

Patient's Address: _________________________________ City: _________________State: _____Zip:_____________

Phone: ____________________ Location home/facility: ___________________Allergies:______________________

Medicare No.:___________________________S.S. No.___________________ Verified: ☐ Pending ☐ Done

Patient's Primary Contact Name: _______________Relationship to Patient: __________ Phone No: ______________

Who should we contact to discuss our services? ___Patient or ___Patient Primary Contact

Has hospice been discussed with patient or family? ___Yes ___ No

Attending Physician or Alt. MD: ______________________________ Clinic/Hospital: __________________________

Address: _____________________________________ Phone: ____________________ Fax: ______________________

Please include: ☐ Hospital discharge date______/___/________ (if applicable)

- ☐ Face Sheet/Demographics (include family contact)
- ☐ Recent History & Physical (and last MD visit notes, or hospital discharge summary)
- ☐ Current list of medications and treatments
- ☐ Any pertinent consultation or diagnostic test reports
- ☐ Copy of Payer/Insurance Card (unless information included on face sheet)
- ☐ Dietary restrictions:__________________________________ Other: ____________________________________

☐ Primary admitting terminal Diagnosis: _______________________________________ DNR: ☐ Yes ☐ No

COMMENTS "Why Hospice Now?" Describe patient decline that precipitated Hospice:

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ORDERS

Attending MD; I will remain attending MD, I will sign the initial Plan of Care and Certification of Terminal Illness as required by the patient's insurance, in addition to all orders regarding my patient. I am available for consultation as needed. I will be notified of important updates and contacted at the time of death. I understand that the BYS Hospice Medical Director Physician may be called in my absence to provide medical consultation and direction if there is a change in the patient's condition and assist with signs & symptoms management.
Additional comments:____

Based on the patient's diagnosis and current condition, I expect this patient has a limited life expectancy of six (6) months or less, if the terminal illness runs its normal course, and hereby certify that this patient is eligible for hospice care. Please evaluate for admittance to hospice.

________________________________ ___/___/_______ ____

PHYSICIAN SIGNATURE Date PHYSICIAN NAME (PRINT)

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