SEQUOIA
HOSPICE INC.

Hospice Referral Form

Phone: (559) 321-8054 Fax: (559) 900-4795

If you have a patient who might benefit from hospice services, please complete and return this form.

REQUIRED INFORMATION

PATIENTS NAME:_____ GENDER: ☐ M ☐ F DOB:_____

PATIENTS ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

PHONE #:_____ LANGUAGE SPOKEN:_____

LIVES: ☐ ALONE ☐ WITH FAMILY ☐ WITH SPOUSE ☐ OTHER:_____

ATTENDING PHYSICIAN:_____

PATIENTS PRIMARY CONTACT:_____ CONTACT #:_____

Who should we contact to discuss our services? ☐ PATIENT ☐ PATIENTS PRIMARY CONTACT

Has hospice been discussed with the patient? ☐ YES ☐ NO With family? ☐ YES ☐ NO

REFERRAL CONTACT NAME:_____ REFERRAL CONTACT #:_____

SUPPORTING INFORMATION

☐ DOCUMENTS ATTACHED TO FAX ☐ PLEASE SEND A REPRESENTATIVE TO COLLECT DOCUMENTS

If you have the following supporting documentation, please provide as appropriate:

- Patient Face Sheet (Demographics)
- Pathology Reports
- History and Physical
- Discharge Summary
- Last Visit Note
- Labs
- Medicare/Medicaid/Commercial
- Insurance Card
- Additional Information

COMMENTS:_____

_____

_____

ORDERS

☐ EVALUATE AND ADMIT TO HOSPICE SERVICES

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.

ADDITIONAL ORDERS:_____

For physicians: please sign here to authorize us to evaluate and admit patient, if eligible.

PHYSICIAN SIGNATURE:_____ DATE:_____

PHYSICIAN NAME (PRINT):_____