Hospice Referral Checklist
Physician Order

To: Hospice by the Bay Admissions Team **Date**: ________________ **Fax: (888) 767.1919**

Phone: (415) 526.5601 **Number of pages** (including cover): ___________

From: _________________________________ **Phone**: ___________________________________

Re: Hospice Referral **Referring Physician**: ____

Patient Name: ____

Social Security No.: __________________________ **Date of Birth**: _________________________

Services Requested:

☐ Informational Meeting Only ☐ Admit Per Patient Preference ☐ Urgent Admission

☐ Other: ____

Please complete and attach to this Fax:

☐ Terminal Diagnosis ____

☐ **I would like to oversee this patient's care as the Attending Physician.**

Contact me by ❑ Fax: ______________________ ❑ Phone _________________________

(We will call you for new orders and changes to patient's condition. For urgent needs, if we are unable to reach you, our nurses will contact our Medical Director.)

☐ **I would like a Hospice by the Bay Medical Director to oversee this patient's care.**

(HBTB will provide regular status updates via fax.)

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.

_____________________________________ _____________________________

Attending Physician Signature Date

❑ Face Sheet/Demographics (include family contact)

❑ Recent History and Physical (and last MD visit note)

❑ Any pertinent consultation reports

❑ Copy of Payer/Insurance Card *(unless information included on face sheet)*

Comments: ____

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We will contact your office upon receipt. Thank you for the referral.

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