Hospice by the Bay

# Hospice Referral Checklist
# Physician Order

**To:** HBTB Admissions Team **Date:** _____ **No. of pages** (incl. cover): _____

**From:** _____ **Phone:** _____ **Fax:** _____

**Re:** Hospice Referral **Referring Physician:** _____

**Services Requested:**

❑ Informational Meeting Only ❑ Admit per Patient Preference ❑ Urgent Admission

❑ Other: _____

Please complete this form and fax to the number below

Toll-Free Fax: (888) 767.1919

Admissions Phone: (888) 720.2111

**Patient Name:** _____

**Social Security No.:** _____ **Date of Birth:** _____

1. **Terminal Diagnosis:** _____

2. **Please include the following:**
   - ❑ 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)*

3. **I want to be (please choose one):**
   - ❑ ***Consulting MD**; I understand all orders will be sent to the Hospice Physician. Please send me bi-weekly updates and an alert at the time of death. I am available for consultation as needed for my patient(s).*
   - ❑ ***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 understand that the HBTB Hospice Physician may be called in my absence.*

   Additional comments: _____

   _____

   - ❑ *Make this an ongoing preference for all my patients.*

4. *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