Palliative & Hospice Care Referral

Patient Name: ______________________________

DOB: ____________________ SSN: ____________________

Address: ______________________________

Phone: ______________________________

Insurance: ______________________________

Caregiver Contact: ____________________ Phone: ____________

Referral Contact: ______________________________

Please include most recent note or medical history.
Select one or both based on your assessment of patient's present condition and needs:

Palliative Care

☐ Order to evaluate and admit for in-home palliative care for serious illness

Comments: ______________________________

____

Hospice

☐ Order to evaluate and admit to hospice, if appropriate

Comments: ______________________________

____

Certification of Terminal Illness:
I certify to the best of my knowledge and medical judgment that patient is eligible for hospice care based on terminal diagnosis and prognosis of 6 months or less if disease runs its normal course.

Provider Name: ____________________ **Date:** ____________

Provider Signature: ______________________________

Hospice Referral Phone: (864) 328-1959 • Palliative Care Referral Phone: (864) 328-1945
Referral Fax: (864) 328-1975 • Referral Email: referral@hospicehouse.net

Thank you for entrusting us to provide the very best palliative and hospice care to your patients!