



A Program of Hospice of Santa Cruz County

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Concurrent Care for Children Referral

To : _____ From: _____ Date: _____

Patient Name: _____ DOB: _____

Home Address: _____

Legal Guardian: _____ Phone Number: _____

Language: _____ Primary Dx: _____

Insurance(s) (Private/Medi-cal/CCS): _____

Current Medical Needs (Pain/Respiratory Mgt /Artificial Food & Fluids/Wound Care/IV's/Special Instructions):

Known current DME in use or Needed:

The patient / patient's representative has identified me as his / her attending physician.

Based on my clinical judgement regarding the normal course of this patient's illness, I certify this patient is suffering from a terminal illness with life expectancy of six months or less.

Recent Medical Records Attached: Yes _____ No _____

I have discussed prognosis with the patient / family: Yes _____ No _____

I will sign the death certificate: Yes _____ No _____

Please anticipate a call from our Concurrent Care for Children team to confirm whether or not your patient has been admitted to our Concurrent Care Program. If admitted, the RN will obtain your authorization to implement the Plan of Care and consent to treat.

Physician Signature: _____

Print Name: _____ Date: _____

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