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Hospice Referral Form

To: _____

From: Admissions Department

Patient Name: _____

Date: _____

D.O.B: _____

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

Based on my clinical judgment regarding the normal course of this patient's illness, I certify that this patient is suffering from a terminal illness with a life expectancy of six (6) months or less.

Yes No Don't Know

I have discussed prognosis with the patient/family

I will sign the death certificate

The patient has current or suicide ideation history

Please anticipate a call from our Admissions Nurse to confirm whether or not your patient has been admitted to Hospice services. If admitted to Hospice, our RN will obtain your authorization to implement the Hospice Plan of Care and consent to treat.

Physician Signature: _____

Print Name: _____

Date: _____

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