Hospice Referral
Request from Physician

To: BTBH 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. 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 BTBH Hospice Physician may be called in my absence.

   Additional comments: ________________________________

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   ❑ *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.*

________________________________ ________________

Physician Signature   Date

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