



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: _____

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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