crossroads
HEALTHCARE AT HOME
an Impact company

HOSPICE REFERRAL FORM

San Francisco Branch
1109 Vicente St. #101 San Francisco, Ca 94116
Tel: 415-682-2111

East Bay Branch
333 Hegenberger Rd. #710 Oakland, Ca 94621
Tel: 510-638-8033

Patient Demographics

Patient Name: *(Last Name, First):* ______________________

Patient Date of Birth: ________/________/________

Patient Address: ______________________

____

Patient Telephone: (______) ________-________

Patient's Sex:
☐ Male ☐ Female

Patient SSN: ________ - ______ - ________

Patient Allergies: ______________________

Person to Contact to Schedule Hospice Evaluation / Admission

Name: ______________________ Relationship: ______________________

Tel: (______) ________-________

Primary Payer Information

☐ **Medicare**: ______________________

☐ **Medi-Cal**: ______________________

☐ **HMO/Commercial Insurance**

Health Plan: ______________________

Policy #: ______________________

Hospice Orders

☒ **Evaluate and if appropriate, admit to Hospice**

Please include a copy of last progress/visit note, medication list and past medical history, along with this completed form

Diagnosis

Primary Diagnosis or Condition for which patient is being referred to service(s):

____

____

Referring Provider Signature

Referring Provider Signature: ______________________ Date: ______/______/________

Print Name of Referring Provider: ______________________ (indicate MD, DPM, DO, NP or PA)

Tel: (______) ________-________ Fax: (______) ________-________

FAX COMPLETED FORM TO: 415-682-2112 OR EMAIL TO: eFAX@CROSSROADSHH.COM